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Appointment of the Under-Secretary of the Pontifical Council for Health Care Workers

On 31 July 2009 the Holy Father appointed Rev. Msgr. Jean-Marie Musivi Mpendawatu Under-Secretary of the Pontifical Council for Health Care Workers for a five-year period. He replaces Rev. Fr. Felice Ruffini M.I., who finishes his service for reasons of age.

So many thanks to Fr. Ruffini for the service that he has rendered over the last twenty-four years as Under-Secretary of the Pontifical Council for Health Care Workers

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Speech of the Holy See Delegation to the 62nd World Health Assembly

18-27 MAY 2009, GENEVA, SWITZERLAND

Mr/Mme Chair:

I wish to present the Holy See's sincere congratulations and good wishes on your appointment to this important office.

Recently appointed by His Holiness Pope Benedict XVI as the President of the Pontifical Council for Health Care Workers, I consider it a great honour to share with the delegates at this 62nd World Health Assembly some of the reflections and concerns of the Holy See. In relation to the impact on health and health-care during this period of global economic crisis, the Holy See shares the preoccupation already expressed by other delegates.

The current crisis has raised the specter of the cancellation or drastic reduction of external assistance programs, especially for less developed countries. This will dramatically jeopardize the state of their health systems, which are already overburdened by endemic, epidemic and viral diseases. Pope Benedict XVI in his message to the G-20 observed that "the way out of the current global crisis can only be reached together, avoiding solutions marked by any nationalistic selfishness or protectionism." He therefore calls for "a courageous and generous strengthening of international co-operation, capable of promoting a truly humane and integral development."[1]

My delegation also wishes to point out the high importance and the particular responsibility that is carried by faith-based organisations and thousands of Church-sponsored health-care institutions in the provision of support and treatment to those living in poverty. The increasing financial burden placed on governments during this economic crisis is felt even more acutely by the Church – sponsored institutions that are often deprived of access to governmental or international funding and yet persevere in the struggle to serve those most in need. The values that motivate such service on the part of faith-based organizations, in addition to the overriding value of the sacredness and dignity of human life, include some of the same principles articulated in the Resolution on Primary Health Care being considered by this Assembly. I refer to principles such as "equity, solidarity, social justice and universal access to services."[2]

Mr/Mme Chair,

In 1998 the Pontifical Council – prompted by the World Health Organization – conducted a research in local Churches on the challenges faced by the international community in the attainment of health for all. The results of this inquiry showed that one of the greatest challenges was the implementation of the principle of equity.[3] A decade later, I am afraid to note that this challenge still holds in most countries. My delegation therefore notes with great attention the resolution concerning the Social Determinants of Health that is proposed for passage by this Assembly and is particularly interested in the urgent plea contained therein for governments "to develop and implement goals and strategies to improve public health with a focus on health inequities." [4]

Furthermore, there is a shared concern for the millions of children globally who do not reach their full potential due to the serious gaps in health equity. This same concern was addressed by Pope Benedict XVI to the participants at the 2008 International Conference of the Pontifical Council for Health Care Workers, when he called for "a decisive action aimed at preventing illnesses as far as possible" among these children and when they are present, treating them "by means of

the most modern discoveries of medical science as well as by promoting better standards of hygiene and sanitation, especially in the less fortunate countries"[5]

Mr/Mme Chair,

We cannot allow such defenseless children, their parents and other adults in low-income communities throughout this world to become even more vulnerable as a result of the global economic crisis, which is largely fuelled by selfishness and greed. Thus the Holy Father insists that we "need a strong sense of global solidarity between rich and poor countries, as well as within individual countries, including affluent ones. A common code of ethics is also needed, consisting of norms based not upon mere consensus, but rooted in the natural law inscribed by the Creator on the conscience of every human being (cf. *Rom* 2:14-15)".[6] Because, "justice cannot be created in the world solely through good economic models, necessary though they are. Justice is achieved only if there are upright people."[7]

Thank you, Mr/Mme Chair.

H.E. Msgr. ZYGMUNT ZIMOWSKI
President of the Pontifical Council for Health Care Workers, the Holy See

Notes

[1] BENEDICT XVI, *Letter to Mr. Gordon Brown ahead of the G20 Summit*, 30 March 2009.
[2] http://www.who.int/gb/ebwha/pdf_files/EB124/B124_R8-en.pdf.
[3] Pontifical Council for Health Pastoral Care, Research on *"Project de document de consultation pour l'actualisation de la stratégie mondial de la santé pour tous"*, Rome 1998, (unpublished text).
[4] http://www.who.int/gb/ebwha/pdf_files/EB124/B124_R8-en.pdf.
[5] BENEDICT XVI, *Address to Participants in the 23rd International Congress on the Pastoral Care in the Treatment of Sick Children*, 5 November 2008, Rome.
[6] BENEDICT XVI, *Message for the Celebration of the World Day of Peace,* 1 January 2009, n. 8.
[7] BENEDICT XVI, *Address to the Parish Priests and Clergy of the Diocese of Rome,* 26 February 2009.

The XVII World Day of the Sick

11 February 2009

Account

The Holy Father Benedict XVI expressed in his Message the following wish: 'I therefore hope that the World Day of the Sick will offer the parish and diocesan communities an opportunity to be ever more aware that they are the "family of God" and will encourage them to make the love of the Lord, who asks that "within the ecclesial family no member should suffer through being in need", visible in villages, neighbourhoods and cities'. In order to put into practice this wish of the Pope it would be appropriate if the above-mentioned Message and the speech of greetings that the Pope offered to sick people during the solemn celebration in the Basilica of St. Peter's on 11 February of this year became the subject of continual reflection, in each parish in particular, in whose area there exist so many *invisible wards*, with the hope that the *deaconate of charity*, an inexhaustible source of spiritual life and a sign of the merciful love of God, would thereby be multiplied The same hope applies to health-care centres and to groups responsible for pastoral care in hospitals throughout the world.

A Summary of the Message

'Human life is beautiful and should be lived to the full, even when it is weak and enveloped in the mystery of suffering'. 'At the same time, I address a heartfelt appeal to the leaders of nations that they will strengthen the laws and provisions for sick children and their families'. 'In fact, it is necessary to assert vigorously *the absolute and supreme dignity of every human life*' which 'is beautiful and should be lived to the full, even when it is weak and enveloped in the mystery of suffering'. 'This year our attention focuses in particular on children, the weakest and most defenceless creatures, and on those of them who are sick and suffering. There are tiny human beings who bear in their bodies the consequences of incapacitating diseases, and others who are fighting illnesses that are still incurable today, despite the progress of medicine and the assistance of qualified researchers and health-care professionals. There are children injured in body and in mind, subsequent to conflicts and wars, and other innocent victims of the insensate hatred of adults'.

The Solemn Concelebration in St. Peter's Basilica

On 11 February, the liturgical memorial of the Immaculate Virgin of Lourdes, a celebration of the Eucharist took place in the Vatican basilica presided over by Cardinal Javier Lozano Barragán. Together with the President of the Pontifical Council for Health Care Workers, the other concelebrants were Cardinal Agostino Vallini,

Cardinak Ivan Dìas, Cardinal Antonio Cañizares Llovera and Cardinal Bernard F. Law. Amongst the bishops present there were the Secretary of the Pontifical Council, José Luis Redrado, and Rino Fisichella, the President of the Pontifical Academy for Life. Around the altar of the confession were gathered a large number of priests of the Pontifical Council, of the diocese of Rome, and numerous spiritual assistants of the UNITALSI and the *Opera Romana Pellegrinaggi*, the two organisations which were responsible for the preparations for this event.

In his introduction to the Holy Mass, Cardinal Javier Lozano Barragán, after greeting the distinguished figures present, greeted the large number of sick people, disabled people, volunteers and agents of pastoral care in health who had come to the basilica from Rome and other parts of Italy. The prelate observed that pain and suffering, especially in the most innocent and the youngest, who are afflicted by illnesses, exploited, the victims of the sex trade and involved in wars, call on all of us to pray for and implore the mercy of God towards mankind.

During the celebration of the Eucharist, the sacrament of the anointing of the sick was administered to ten people.

The Meeting of Benedict XVI with the Sick in the Vatican Basilicata

The Holy Father Benedict XVI, who arrived in the basilica at the end of the Eucharist, offered those present a profound reflection on the inestimable value of life.

'Human life is not a disposable good but a precious coffer to be preserved and looked after'; 'faith helps us to consider human life beautiful and worthy of living to the full, even when it is undermined by evil'; 'With his passion and his death [Christ] took our weakness upon himself and totally transformed it'; 'My venerable Predecessor John Paul II wished the World Day of the Sick to coincide with the Feast of the Immaculate Virgin of Lourdes. In that sacred place, our heavenly Mother came to remind us that on this earth we are only passing through and that the human being's true and definitive dwelling place is Heaven. We must all strive for this goal'.

After the address of the Pope the lights went out and the faithful, after lighting candles, sung the Ave Maria of Lourdes. This was a very beautiful and atmospheric moment which evoked the atmosphere of the Marian sanctuary with its torchlight processions. The Holy Father, visibly moved by the atmosphere that had been created during his meeting with the sick, blessed them and stopped to personally greet about twenty people in wheelchairs, together with very many other sick people who were present with those who accompanied them, who that evening joined in prayer with the successor to St. Peter.

Msgr. DARIUSZ GIERS
Official of the Pontifical Council for Health Care Workers, the Holy See.

Angelus

SAINT PETER'S SQUARE, SUNDAY, 8 FEBRUARY 2009

Dear Brothers and Sisters,

The Gospel today (cf. Mk 1: 29-39) in close continuity with last Sunday's presents to us Jesus who, after preaching on the Sabbath in the synagogue of Capernaum, heals many sick people, beginning with Simon's mother-in-law. Upon entering Simon's house, he finds her lying in bed with a fever and, by taking her hand, immediately heals her and has her get up. After sunset, he heals a multitude of people afflicted with ailments of every kind. The experience of healing the sick occupied a large part of Christ's public mission and invites us once again to reflect on the meaning and value of illness, in every human situation. This opportunity is also offered to us by the World Day of the Sick which we shall be celebrating next Wednesday, 11 February, the liturgical Memorial of Our Lady of Lourdes.

Despite the fact that illness is part of human experience, we do not succeed in becoming accustomed to it, not only because it is sometimes truly burdensome and grave, but also essentially because we are made for life, for a full life. Our "internal instinct" rightly makes us think of God as fullness of life indeed, as eternal and perfect Life. When we are tried by evil and our prayers seem to be in vain, then doubt besets us and we ask ourselves in anguish: what is God's will? We find the answer to this very question in the Gospel. For example, in today's passage we read that Jesus "healed many who were sick with various diseases, and cast out many demons" (Mk 1: 34); in another passage from St Matthew it says that Jesus "went about all Galilee, teaching in their synagogues and preaching the Gospel of the Kingdom and healing every disease and every infirmity among the people" (Mt 4: 23). Jesus leaves no room for doubt: God whose Face he himself revealed is the God of life, who frees us from every evil. The signs of his power of love are the healings he performed. He thus shows that the Kingdom of God is close at hand by restoring men and women to their full spiritual and physical integrity. I maintain that these cures are signs: they are not complete in themselves but guide us towards Christ's message, they guide us towards God and make us understand that man's truest and deepest illness is the absence of God, who is the source of truth and love. Only reconciliation with God can give us true healing, true life, because a life without love and without truth would not be life. The Kingdom of God is precisely the presence of truth and love and thus is healing in the depths of our being. One therefore understands why his preaching and the cures he works always go together: in fact, they form one message of hope and salvation.

Thanks to the action of the Holy Spirit, Jesus' work is extended in the Church's mission. Through the sacraments it is Christ who communicates his life to multitudes of brothers and sisters, while he heals and comforts innumerable sick people through the many activities of health-care assistance that Christian communities promote with fraternal charity. Thus they reveal the true Face of God, his love. It is true: very many Christians around the world priests, religious and lay people – have lent and continue to lend their hands, eyes and hearts to Christ, true physician of bodies and souls! Let us pray for all sick people, especially those who are most seriously ill, who can in no way provide for themselves but depend entirely on the care of others. May each one of them experience, in the solicitude of those who are beside them, the power and love of God and the richness of his saving grace. Mary, health of the sick, pray for us!

Address of His Holiness Benedict XVI to the Sick, at the End of the Eucharistic Celebration Presided over by Cardinal Javier Lozano Barragán, in St. Peter's Basilica, on the XVII World Day of the Sick, Memorial of Our Lady of Lourdes

WEDNESDAY, 11 FEBRUARY 2009

Dear Sick People,
Dear Brothers and Sisters,

Our meeting has a special value and significance: it is taking place on the occasion of the World Day of the Sick which occurs today, the Memorial of Our Lady of Lourdes. My thoughts turn to that Shrine which I too visited on the occasion of the 150th anniversary of the Apparitions to St Bernadette. And I have kept a vivid memory of that *pilgrimage* which was focused in particular on the contact I had with the sick gathered at the Grotto of Massabielle. I have come very gladly to greet you at the end of the Eucharistic celebration at which Cardinal Javier Lozano Barragán, President of the Pontifical Council for Health Care Workers, has presided. I address a cordial thought to him. Together with him I greet the Prelates present and the priests, men and women religious, volunteers, pilgrims and especially the beloved sick people and those who care for them daily. It is always moving to relive in this circumstance, here, in St Peter's Basilica, that typical atmosphere of prayer and Marian spirituality which characterizes the Shrine of Lourdes. Thank you, therefore, for this expression of your faith and love for Mary; I thank all those who have sponsored and organized this event, especially UNITALSI [the Italian National Union for Transporting the Sick to Lourdes and International Shrines] and the *Opera Romana Pellegrinaggi* [Roman Society for Pilgrimages].

This Day invites us to feel with greater intensity the spiritual closeness to the Church's sick which, as I wrote in the Encyclical *Deus caritas est,* is the family of God in the world within which no one must go without the necessities of life (cf. n. 25b). At the same time, today we are given the opportunity to reflect on the experience of illness, suffering, and more generally, on the meaning of life to be lived to the full even in suffering. In the *Message for today's event,* I wished to focus attention on sick children who are the weakest and most defenceless of creatures. It is true! If we are left speechless before an adult who is suffering, what can we say when illness affects an innocent child?

How is it possible to perceive the merciful love of God, who never abandons his children in trial, even in these difficult situations? Such questions are frequent and at times disturbing. Truly, they find no adequate answers on the merely human level since the meaning of pain, illness and death remains incomprehensible to the human mind. However, the light of faith comes to our aid. The Word of God reveals to us that even these ills are mysteriously "embraced" by the divine plan of salvation; faith helps us to consider human life beautiful and worthy of living to the full, even when it is undermined by evil. God created the human being for happiness and for life, while illness and death entered the world as a consequence of sin. However, the Lord has not left us to ourselves. He, the Father of life, is the physician of man par excellence who ever lovingly bends over suffering humanity. The Gospel shows Jesus who "cast

out the spirits... and healed all who were sick" (Mt 8: 16), pointing out the way of conversion and faith as conditions for obtaining healing of body and mind. With his passion and his death he took our weakness upon himself and totally transformed it. This is why according to what the Servant of God John Paul II wrote in his Apostolic Letter *Salvifici doloris "To suffer* means to become particularly *susceptible,* particularly *open to the working of the salvific powers of God,* offered to humanity in Christ" (n. 23).

Dear brothers and sisters, we are increasingly realizing that human life is not a disposable good but a precious coffer to be preserved and looked after with every possible attention, from the moment of its origin to its ultimate natural end. Life is a mystery that in itself demands responsibility, love, patience and charity, on the part of each and every one. It is especially necessary to surround those who are sick and suffering with care and respect. This is not always easy; yet we know where to find the courage and patience to face the vicissitudes of earthly existence, and in particular sickness and every kind of suffering. For us Christians, it is in Christ that the answer is found to the enigma of pain and death. By participating in Holy Mass, as you have just done, we are immersed in the mystery of his death and Resurrection. Every Eucharistic celebration is the perennial memorial of the Crucified and Risen Christ, who defeated the power of evil with the omnipotence of his love. It is therefore at the "school" of the Eucharistic Christ that we are granted to learn and to love life always and to accept our apparent powerlessness in the face of illness and death.

My venerable Predecessor John Paul II wished the World Day of the Sick to coincide with the Feast of the Immaculate Virgin of Lourdes. In that sacred place, our heavenly Mother came to remind us that on this earth we are only passing through and that the human being's true and definitive dwelling place is Heaven. We must all strive for this goal. May the light that comes "from on High" help us to understand and to give meaning and value to the experience of suffering and death too! Let us ask Our Lady to turn her motherly gaze on every sick person and on his or her family, to help each one to carry the weight of the Cross with Christ! Let us entrust to her, the Mother of humanity, the poor, the suffering, the sick of the whole world, with a special thought for suffering children! With these sentiments, I encourage you to trust in the Lord always and I warmly bless you all.

The World Day of the Sick in the Spanish Church

The world of pastoral care in health in Spain received the creation of the World Day of the Sick with joy and satisfaction. Because of its own experience, it was convinced that the celebration of this day would be a very good thing for sick people, for those who help them and treat them, for those who work in the sphere of pastoral care in health, and for the Church as a whole.

Ever since 1985, on the sixth Sunday of Easter, the World Day of the Sick has been celebrated and this celebration, which has been received with warmth and interest ever since it began, is without doubt one of the most significant and fecund activities of pastoral care in health. This celebration has acquired increasing relevance and has produced results: the recognition that sick people are active individuals; the impulse given to pastoral care in health in parishes; initiatives taken in many dioceses based upon this day; an abundance of liturgical and doctrinal material produce for catechesis; the work of cooperation and coordination between delegations and various kinds of agents of pastoral care: and an increasing appreciation of pastoral care in health within the whole of the Spanish Church, etc.

When John Paul II established the World Day of the Sick as an official appointment to be celebrated on 11 February, the feast of Our Lady of Lourdes, the Episcopal Commission for Pastoral Care thought it necessary for the Department for Pastoral Care in Health to analyse together with the diocesan delegations how the celebration of the Day of the Sick in Spain could be integrated with the World Day of the Sick without losing its enormous riches.

We were aware that the day was to be an intense moment of prayer, of communion, of the offering up of pain for the good of the Church, and an appeal to everybody to recognise in the face of their sick brother the Face of Christ who, in suffering, dying and rising again, achieved the salvation of mankind. In addition, it had to be done in harmony with local needs and circumstances given that one could not forget the importance of its target – the People of God, the many Catholic health-care institutions, and civil society.

The Day of the Sick thus came to be the culminating point of a campaign that begun with the National Meeting of Delegates in the month of September and included a large number of initiatives, some at a national level, some at a local level, and yet others at a diocesan level.

Using the experience that had been accumulated in the past and the results that had been produced, an attempt was made to link the World Day of the Sick with the beginning and the middle of the Campaign for the Sick. The National Days of the Delegates, at the end of September, are the beginning of the course and the moment to begin: once a specific subject has been decided and the general orientation has been settled, initial work involving study, analysis and the creation of documents begins.

The World Day of the Sick is the central point of the course and the campaign. There is a first stage of work involving study and reflection, and the drawing up of materials and documents, which goes from September to February, and which allows the World Day of the Sick to be the beginning and the solemn inauguration of the whole of the campaign. The Message of the Holy Father constitutes the point of reference and, together with the material drawn up by the Department for Pastoral Care in Health and the diocesan delegations, it makes up the preparatory terrain for pastoral work that takes place in every diocese and in parish and hospital Christian communities.

11 February is the date when the diocesan Church celebrates the World Day of the Sick together with the universal Church. Each diocese has its own specific form of doing this and its own specific planning for the occasion: a cycle of conferences, a diocesan or inter-diocesan day, or presence in the mass media (the press, radio and television). A diocesan initiative presided over by a bishop confers unity and solemnity on the celebration.

This is the first important action of a campaign that continues over the next months until Easter with the celebration of the Easter of the Sick. Both these celebrations, namely the World Day of the Sick and the Easter of the Sick, constitute the solemn inauguration of the campaign and its closure or termination. The activities that each diocese engages in during this period and from one date to another are many in number and varied in character. 11 February, for many dioceses, is a diocesan celebration. The period of Easter, the Easter of the Sick, is a more specific celebration and takes place in a parish context, in hospital centres or in rest homes.

The Department
for Pastoral Care in Health,
the Spanish Bishops' Conference.

The World Day of the Sick in Bolivia

On 11 February is celebrated the World Day of the Sick, a suitable opportunity to reflect on human pain and our solidarity towards our brothers and sisters who are in a situation of need.

Illness brings out the whole of human frailty and places the person who suffers in a world full of questions. As disciples/missionaries of Jesus Christ we must bring hope and care to the weak because only in this way do we sincerely show that we love Jesus. The Gospel of Matthew reads: ''Lord when did we see thee sick or in prison and visit thee? And the King will answer them, 'Truly, I say to you, as you did it to one of the least of brethren here, you did it to me'' (25:39-40).

We wish to express our nearness to our sick brethren and to say that we pray for them. We know that communal prayer is effective because the Lord assured us that 'where two or three are gathered together in my name, I am amongst them' (Mt 18:20).

When we are sick we find ourselves immersed in worries, in intentions and in memories but we also manage to find the strength that comes from other people and which is manifested in the discovery of brothers and sisters who pray and invoke help for us.

We sincerely thank all those who work in pastoral care in health because through their generous devotion they impress a more human and gospel face on care and assistance for the sick. Their free and humble presence, which is marked by commitment, makes present Christ the Good Shepherd who gives life to those who suffer, in body and spirit, the signs of human frailty.

We appeal to all men and women of good will to work to achieve the overall health of people because pastoral care in health is not something that regards only voluntary workers but is something that concerns the whole population of Bolivia. One is not dealing with mere assistance to those who are injured in their health but of recognising that every person deserves to be cared for and treated in the best way possible given that this is a human right.

We recognise the role of large numbers of medical doctors, nurses and auxiliaries who through their devotion and their generosity work to humanise health-care centres and to ensure that patients are treated as people and even more as children of God who strive for their fulfilment despite illness and pain.

The letter of James tells us: 'Is any one among you suffering? Let him pray. Is any cheerful? Let him sing praise. Is there any among you sick? Let him call for the elders of the church, and let them pray over him, anointing him with oil in the name of the Lord; and the prayer of faith will save the sick man' (Jm 5:13-15)

Thanks to everyone for the solidarity, fraternity and faith that they share with their sick brethren. May the Lord Jesus, who passed by doing good and healing all kinds of illness, bless you with abundant graces!

Msgr. WALTER PÉREZ VILLAMONTE,
Bishop of the Diocese of Potosi, President of the Department of Health, the Bishops' Conference of Bolivia.

The World Day of the Sick, Iraq, Baghdad

Uniting itself to the appeal of the Holy Father, Pope John Paul II, which was launched in his speech of 11 February 1992 when he called for a day to be dedicated to the sick, the Church in Iraq every year celebrates the World Day of the Sick with all the associations and communities that care for the sick and the handicapped.

With the blessing of the apostolic nunciatures in Iraq and His Excellency Msgr. Matti Shaba Matoka, the Archbishop of the Syriac Catholics and the various Catholic bishops of the diocese of Baghdad, and a large number of relatives, friends and acquaintances, this year the World Day of the Sick was celebrated on 14 February in the Church of Saint Mary of the Syriac Catholics.

This day began with a procession of the most holy Eucharist, preceded by all the participants and children dressed as angels in the cathedral, where the Patriarch of the Chaldeans and other bishops, the representative of the apostolic nunciatures Don Matteo

de Mori, and other priests, monks and sisters belonging to various congregations, were waiting

The Mass was presided over by Fr. Thaer Saad Allah with all the concelebrating priests and representatives of the various churches of Baghdad. Fr. Philip Domenicano presented the offerings brought to the altar (the Bible, bread, wine, small stones), accompanied by the song 'Children of a Church'.

The liturgy of the word contained a long reading of the first letter of St. Paul to the Corinthians (1 Cor 12: 12-31) and a passage from the Gospel of John (Jn 5: 1-9). The sermon concentrated on the salvific value of faith and love which enable us to bear our pains and be at one with the whole of suffering humanity. The intercessions of the people of God prayed for peace and prosperity in the country and the ending of violence in Iraq. During the exchange of the peace of Christ some sick people began to go amongst the congregation and to distribute 'red hearts' made specially for the occasion to celebrate this day of love and to say that the sacrifice of Christ on the cross is great love.

At the end of the celebration the queen of the year was chosen. A (handicapped) girl aged twelve called Farah (joy) was chosen to be the queen of 2009. She was crowned by last year's queen to the great joy of everyone.

The day finished with songs and the exchange of good wishes and greetings, with thanks being offered to the Lord our God for giving us the grace of being Christians and of suffering with Him, and being redeemed by the cross.

Taiwan, the World Day of the Sick

1. A Mass that touched deep inside the heart

In order to put into practice what the Pope had said about concern for the poor and weak of the world, a solemn Mass on the World Day of the Sick was celebrated in St. John's parish of Panchìao on 15 February (Sunday), organized by the Taipei Archdiocese, together with the Camillians, the Association of the Friends of the Camillians, and the Catholic Friends of the Sick Association. The main celebrant was Fr. Raimondo Yang MI, Spiritual Director of the Friends of the Sick of the Taipei Archdiocese. The Mass was concelebrated by Fr. Antonio Lin, Spiritual Director of the National Catholic Friends of the Sick Association, Fr. Giovanni Rizzi MI, and Fr. Francis Hsu SJ. The choir of St. John Bosco Church, with its very fine voices, was invited to be responsible for the liturgical music. Nearly 350 participants, including Fr. Lin Chih Nan, Spiritual Director of the Prayer Room of Minsheng Hospital of Taoyuan, Director Sr. Chen Bau Ju, Camillian brothers and sisters, sisters of the Franciscan Missionary Sisters of Our Lady of Sorrows, the Missionary Sisters of Providence, the Missionary Sisters Servants of the Holy Spirit, the Sisters of Providence of Portieux, and the Missionary Sisters Oblates of the Holy Family. Mr. Thaddeus Jao, President of the Taipei Archdiocesan Council of the Lay Apostolate, and his team raised up their hearts during the nearly two hours of thanksgiving, Mass and benediction of the Holy Eucharist. The participants were completely immersed in prayer, in the grace of praising God for His love.

The World Day of the Sick was inaugurated by Pope John Paul II in 1993 on the Feast Day of Our Lady of Lourdes, on 11 February, of every year. The Pope advised the sick to pray for health through the intercession of Our Lady and he invited the faithful of the whole world to be united in caring for the poor and the sick. This year Pope Benedict XVI affirmed the absolute dignity of human life. He wished to raise up the consciousness of the 'family of God'. The Church herself is a family and she should imitate the spirit of the Good Samaritan by bearing suffering in common and bearing witness to charity.

The readings at the Mass described the redeeming love of God, encouraged us to imitate Jesus and love one another, and reminded us of the need to share sufferings with poor and sad people. The Gospel pointed out the greatest commandments: one is to love God and the other is to love others as you would like to be loved. Fr. Yang in his homily observed: "God wants us to love, God is the first one to love us, only love can heal the body, soul and heart." Selfish desire and sin creates division between men and God and with others, so we can be healed only with God's love and forgiveness. This means that if we want to be healthy, first of all our spiritual "leprosy" should be purified. There is no other way; we can rely only on Jesus.

As regards the question that is often asked, "why is there sickness?", Fr. Yang explained

that God created us healthy and at peace; sickness was not the original will of God "because men accepted erroneous thoughts and mentalities, their capacity for recovery is constrained; sin blocks life energy, so sickness has space to come out." But the mercy of God sent his loving Son to become man, who redeemed us on the cross; man's suffering is transformed into the strength of hope. This strength is the love of God, it manifests the grace of redemption, so "an answer for sickness and suffering can be found only in Jesus Christ."

The Blessed Sacrament was exposed immediately after the Mass. Four priests knelt in front of the altar; they led the faithful in adoring the presence of Christ. At the same time, they offered prayers and hymns for sick people — those suffering physically and spiritually, sinners in families, health-care workers and volunteers who care for the sick, asking that they be healed and released, pleading God to manifest His glory, to grant strength both to those who face suffering and to those who serve Christ in those who are suffering. Everyone in the whole church seemed to be consoled and enlightened by our Lord Jesus Christ through the presence of the Holy Sacrament. It was solemn, warm and calm; many of the faithful had tears in their eyes.

In order to bestow a special blessing on the participants, Fr. Yang blessed them with the Blessed Sacrament in the monstrance, The other three priests prayed for them by a laying on of hands. A long line of the sick went forward to receive this special grace, accompanied by harmonious hymns. One member of both the Legion of Mary and the Camillian Friends said that at the moment when his forehead was touched by the monstrance he was consoled by the light of God; he felt that he was very warmly embraced by a father, his wound was healed, he felt very little but the grace and love of God were immensely great!

Fr. Yang encouraged everybody with the words of Jesus: "Come you who are blessed by my Father! Receive the kingdom prepared for you since the beginning of creation! Because when I was sick, you came to visit me." He reminded us that the spirit of serving the sick is not limited only to the World Day of the Sick – we should implement it in our daily lives. This grace of the Sacrament will fill the life of the faithful continuously; we share and bear witness by "serving the Lord ardently with joy in our hearts."

Mr. Pan Chung Ching, the Chairman of the Catholic Friends of the Sick Association, addressed those present after the ceremony. He thanked the Archdiocese of Taipei for their big effort in making the Day known about and for the comprehensive planning carried out jointly by different groups. He also thanked the volunteers for everything they had done and expressed his thanks for the generous support of Fr. Ngoc Diep Nguyen and the parishioners of St. John's parish, as well as all the priests, seminarians, sisters and faithful. May they enjoy peace in all senses with the abundant blessing of God. See you next year!

2. Rite of Blessings on the World Day of the Sick in the Diocese of Taichung

To celebrate the World Day of the Sick of 11 February, a rite of blessing was held on 14 February at the cathedral of the diocese of Taichung. We hoped that through prayer and blessing those who are suffering from illness and their families would gain spiritual health and peace.

Beginning at 1.00 pm on that same day, health-care personnel from the clinics of the mid-west areas, the Jen Ai Hospital, etc., provided various medical services and consultations. Then Bishop Su presided over the rite of blessing at 2.30 pm. As a result of the publicity and assistance provided by the Chung Sheng Broadcasting Station, the Catholic Service Group in the Veterans' General Hospital (Taichung), the Stella Matutina Social Welfare Foundation, the St. Mary Social Welfare Foundation, and the Third Order of Dominicans, more than four hundred people who long for both physical and spiritual peace carne from the St. Coletta Training Center for Exceptional Youth, the Catholic Chih Ai Mercy Hospice and the St. Mary Center. They all received superlative blessings from God.

At the beginning of the rite of blessing, Bishop Su sprinkled holy water on everybody, praying for a healing of hearts through holy water. The bishop encouraged those present with the theme of the message of the Holy Father for the World Day of the Sick, emphasizing the "absolute highest dignity of human life", awareness of the needs of others and especially of children. If an adult feels helpless when confronted with suffering, how about these children faced with incurable illnesses, physically and spiritually hurt by war, homeless, without the warmth of family, living by themselves, hungry and lacking medical care, and forced to leave their own countries? Addressing the unfortunate situations of innumerable children, the Pope had thanked the organizations of the Church dedicated to lessening the sufferings of these children, as well as the many people who serve the sick. These are examples of the valuable witness of the Church to love of life, especially the lives of the weak.

Many persons go to Lourdes continuously. This is because the intercession of Our Lady, besides bringing the healing of physical sufferings, more importantly brings reconciliation with God and a change of life. We can see that many people dedicate themselves to charitable services because they have experienced the true value of life. This is a very great gift which comes from heaven. So, do not refuse the invitation of Our Lady to unite your sufferings to those of Jesus! Through our faith and conversion there will be strength to help us to be reborn again and to live out the beauty of life. We also offered prayer cards of intercession for

those who were not able to come. We engaged in an adoration of the Holy Eucharist accompanied by the statue of Our Lady of Lourdes. Jesus came to us through the sacrament of the Eucharist — how precious it was to be nurtured by our spiritual food! We can be at peace only when we open our hearts to welcome Jesus. After guiding everybody in prayer in front of the statue of our Lady, Bishop Su blessed those present with the laying on of hands. He wished that they would have hope and desire, concern for the "littlest brothers" generously and without self-interest by imitating Jesus, and learn how to shoulder together the painful situation of their families in order to let them experience the strength of God's love and abundant graces through these instruments of help.

3. The St. Martin de Porres Hospital: Concern and Blessing for Health

The activities of prayer for the World Day of the Sick 2009 of the Chiayi Diocese were organized by the St. Martin de Porres Hospital, supported by the Diocesan Council for the Lay Apostolate, together with members of the faithful and catechumens. The activities were begun by Bishop Thomas Chung and other priests who gave blessings through the laying on of hands. This was followed by eleven stations of activities. Smiling faces of satisfaction and joy could be seen both on the organizers and the participants.

The first activity was songs performed by the young people of the diocese; these warmed up the atmosphere. Then there were hymns sung by the volunteers and the staff of the Pastoral Care Department of the hospital. The bishop and the director of the hospital addressed those present with warm feelings. They made everyone recognize their mission more clearly, especially the need to be concerned about our little brothers and sisters who are sick and weak. This was followed with a rite of prayer for all those present. We also prayed for all the sick. This was very touching and a beautiful gift from God. We were convinced that we were filled by the Holy Spirit. We also prayed for the guidance of the Holy Spirit to fill up what is lacking in every person. The last activity was the "health stations". At the first station the animators had participants wear eyeglasses, creating poor sight, and had them try to walk or to make a chain with beads in order to let them experience the difficulties of being an aged person, inviting participants to consider what we, as normal people, can do for them. This activity was very effective.

The second station, a house for an Alzheimer's' community, was organized for Alzheimer's patients, showing how they can live in a community and fight the disease. This allowed guests to know how to accompany patients and create a community life for them. The third station gave information on the Our Lady of China Social Welfare Charitable Works Foundation and the Huang Ting Social Welfare Charitable Works Foundation. The fourth station was a health appointment. The Center for Health Control advised those present on how to maintain good health, on how to love one's own health before concerning oneself with the health of others. It described health education, the activities of the "120 Club" (for friends of diabetics), health care for kidneys, the "club of loving your liver", the "club of loving always" (friends with cancer of the large intestine), the "club of dawn" (friends with breast cancer), the "loving club" (friends with cancer of the mouth), etc. Through these games, led by the communities of the friends of the sick and personal sharing, volunteers made an appeal to everybody to pay attention to the importance of their own health

Australia

LETTER OF THE ARCHBISHOP OF ADELAIDE TO H.E. MSGR. ZYGMUNT ZIMOWSKI

Your Excellency,

Following your appointment by Pope Benedict XVI as President of the Pontifical Council for Health Pastoral Care, let me take this opportunity to congratulate you on your appointment, and to send you greetings and best wishes from the Church and Catholic people of Adelaide, South Australia. This also affords an opportunity to briefly report on the various local actions and developments which have taken place since Adelaide had the great honour of hosting the XIV World Day of the Sick in February 2006, organized around the theme: "Mental Health and Human Dignity".

We have many warm memories of the presence of your predecessor, His Eminence Javier Cardinal Lozano Barragán, who visited our city as the Papal Legate for the celebration of the XIV World Day of the Sick. We recall with gratitude that, along with other members of the Pontifical Council, he was able to engage in pastoral visitation of some of our health care facilities, and especially to visit the Hutt Street Centre for Homeless People in the heart of our city. We remember, too, the important contribution of Cardinal Lozano Barragán and the message he delivered during the formal discussions at the Adelaide Convention Centre, culminating in the profoundly moving solemn Eucharistic concelebration in our Adelaide Cathedral on 11 February.

The celebration of the XIV World Day of the Sick in Adelaide, together with the presence of and interchange between members of the Pontificial Council for Health Care Workers, health care consumers, workers, professionals and experts from across Australia and the world, provided not only a focus for attention to issues of mental health and human dignity, but was also a timely spur to action on the part of church, government, and civil society.

The resulting attention and action following the celebration of XIV World Day of the Sick in Adelaide can be considered under four key headings and themes:

– Medical Care

– Pastoral Care for Individuals and Families

– Education and Training

– Media and Public Advocacy.

Many of the themes and recommendations which arose during the formal sessions at the Adelaide Convention Centre have resonated with the approach and actions at the level of Government on the part of the South Australian Government's Social Inclusion Unit, under the leadership of Monsignor David Cappo. In this way, the celebration of World Day of the Sick provided an opportunity for individuals, families and experts to raise their voices, and for some of their key concerns to become the focus for Government and community action.

1. Medical Care

During the Pastoral Day, medical care emerged as a very significant area for concern and change. While there was a degree of sympathy for those charged with administration of the health system, and an understanding of the great pressures on that system, urgent changes were recommended and improvements called for in relation to the critical areas of coordination and integration of services; balancing needs for patient privacy with constructive engagement with families ad carers; and skills development for medical professionals.

In the period since the World Day of the Sick, the South Australian Social Inclusion Board has presented its report into Mental Health, "Stepping Up: A Social Inclusion Action Plan for Mental Health Reform". The report, which followed extensive public consultation, offered 41 recommendations for change in this area, and proposed a five-year action plan for the period 2007-2012.

The South Australian Government drafted new legislation on mental health and after public consultation presented the *Mental Health Bill* in June 2008. Key reforms in the legislation include: a clear articulation of the rights of mental health service consumers and carers; greater emphasis on community care beyond hospital and institutional care; the recognition of the particular circumstances of children, and acknowledging the unique cultural perspective of Aboriginal and Torres Strait Islander people.

Important changes identified during consultations for the XIV World Day of the Sick 2006 have been included in the draft legislation:

– Family access to information that seeks to balance the rights of the individual and the need for those caring for their family member.

– Recognition of the specific needs of Aboriginal South Australians and people from different cultural backgrounds;

– Services that better meet the needs of those living in rural communities;

– Recognition of the vital importance of family members and carers and their needs in balance with the needs of the individual.

2. Pastoral Care for Individuals and Families

The major issue most commonly raised during our celebrations of XIV World Day of the Sick was the urgent sup-

port required for families dealing with mental illness.

One parish, in the city suburb of Norwood, has responded directly to the World Day of the Sick Pastoral Day by establishing the Norwood Parish Companions program to respond to the personal and pastoral needs of people living with a mental illness and their families. The aim of the initiative is to care for the physical, mental, emotional, social and spiritual wellbeing of every individual within the parish through the provision of care and information. It is intended that this initiative will fill the gaps left by existing social services and will complement the excellent work already being done by existing groups in the parish. It is a grass-roots initiative, run by parishioners, for the local community.

At the level of the Archdiocese, I was happy to launch the *Compeer* program in November 2007, in conjuction with the State Council of the Society of St Vincent de Paul in South Australia. The *Compeer* program is conducted and coordinated by the Society of St Vincent de Paul, with the support of the Archdiocese through Diocesan agencies such as Centacare Catholic Family Services and the Adelaide Catholic Justice and Peace Commission. The program provides personal support for individuals living with a mental illness, by matching carefully selected individuals with trained and supervised volunteers who offer companionship and support through regular meeting and conversation. Through the Society of St. Vincent de Paul, this program draws volunteers from parishes and the local community. Training, ongoing supervision and continuing support is provided by *Compeer* to prepare volunteers and enable them to function effectively in their role.

3. Education and Training

The need for education and training for specific groups also emerged as another common recommendation for action in discussions during the XIV World Day of the Sick.

In line with the State Social Inclusion Board's *Action Plan for Mental Health Reform 2007-2012,* the State Government has announced a training initiative for the non-government mental health sector to support the development of its workforce and build up its capacity to deliver high quality services. The Government has also provided funding to non-government organisations to enhance their governance arrangements as part of a broader capacity-building program aimed at improving services to people with mental illness.

At the level of the National Government, a number of Australian Government funded services arising from the Council of Australian Governments' *National Action Plan on Mental Health 2006-2011* are now being delivered in South Australia. Some of these programs include services for personal helpers and mentors, support for day-to-day living and better access to psychiatrists, psychologists and general practitioners through the Government's Medicare Benefits Scheme.

At the level of our local Church, both the *Compeer* and Norwood parish programs offer initial training and ongoing formation for individuals who provide personal support and companionship to people living with a mental illness.

4. Media and Public Advocacy

The need for public education, awareness-raising, increasing understanding and de-stigmatising mental illness were all repeatedly raised in sessions during the XIV World Day of the Sick. The Church was recognised as having a key role to play in presenting a positive image of people suffering with mental illness. Many spoke of the need for the Church to be active as an advocate on behalf of consumers, carers and their families, and to make use of its own networks to help with education and awareness-raising.

Our diocesan newspaper, *The Southern Cross,* has carried a series of articles over the last two years, highlighting the situation and challenges faced by people living with mental illness, and some of the ways in which the Church and local community are responding to these needs and challenges.

Monsignor David Cappo has taken strong leadership role in the State of South Australia on mental health issues in the public forum, including in his capacity as the South Australian Commissioner for Social Inclusion. The Social Inclusion Board was responsible for proposing the State's *Action Plan for Mental Health Reform 2007-2012*, and is now also responsible for overseeing the implementation of the Plan's 41 recommendations.

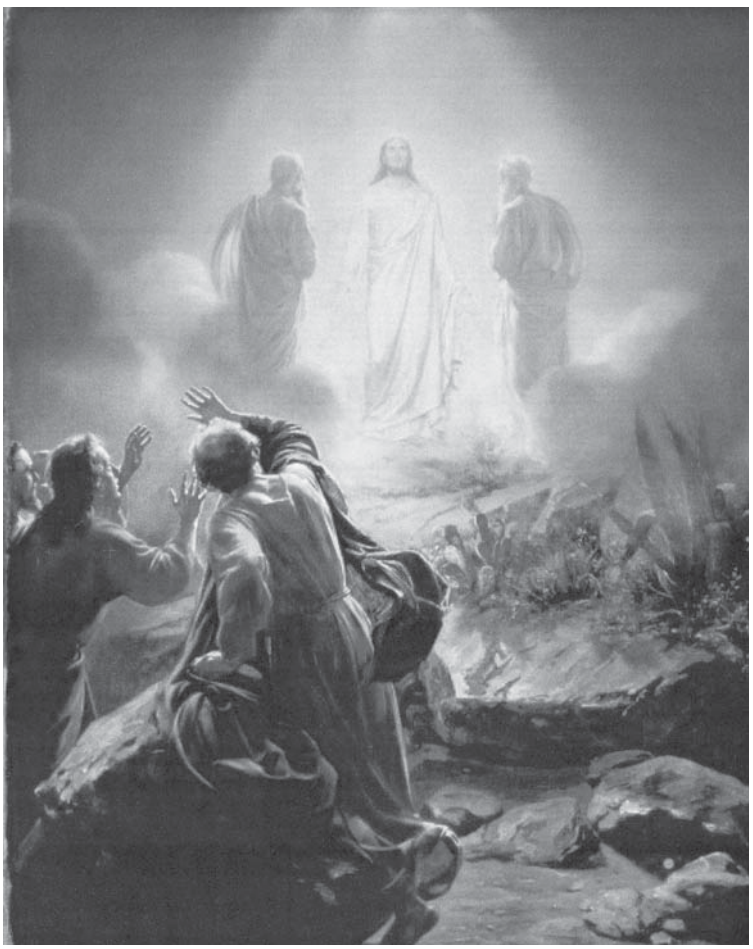
The Adelaide Catholic Justice and Peace Commission

and the Society of St Vincent de Paul have both worked to develop awareness of issues relating to mental health in the Church and wider community. In the lead-up to the last South Australian State Election in 2006, the Adelaide Catholic Justice and Peace Commission presented a series of questions for all candidates concerning mental health and human dignity, and asked them to commit themselves to providing adequate and appropriate levels of care for those with mental health problems, particularly in relation to vulnerable groups such as children, adolescents, the aged, Indigenous Australians, those who are socially and geographically isolated, and those incarcerated in State prisons.

Of course, much remains to be done in relation to each of these areas to realize the dignity of all people regardless of their health status, but I am confident that the seeds planted by the celebration of the XIV World Day of the Sick in Adelaide in 2006 will be a spur to further action and commitment, and that these initiatives will bear great fruit over time.

Again, congratulations on your appointment, and God's blessings on the work of the Pontifical Council for Health Care Workers. Please pass on my prayers and kindest regards to Cardinal Lozano Barragán. Please also pass on our best wishes to your collaborators at the Pontifical Council, and assure them of our prayers and encouragement as you prepare for XVIII World Day of the Sick in 2010.

H.E. Msgr. PHILIP WILSON
DD JCL
Archbishop of Adelaide, Australia



Topics

The Faith of Priests in Limit Situations

Human Resources in Catholic Health-care Structures: what Sustainability for the Future?

Hospitals as Settings for the Exploration and Practice of Hope

The Mental Capacity Act 2005: Bioethical Assessments

Prior Decisions Concerning Life: a Guide for Catholics

Accompanying the Family

The Faith of Priests in Limit Situations

I was asked to write on the faith of priests in the limit situations of life. I will do this not with a theoretical analysis but through the testimonies of a number of brothers that they themselves wrote and which were transmitted by people near to them who received the gift of accompanying them and of listening to their inner thoughts and feelings. First, however, I will briefly describe the experiences that human illness and death involve.

Almost always illness is a painful surprise that provokes an obligatory and forced stop in the flow of life. We have to address in the first person something that we did not expect and which threatens to change our lives.

Illness provokes a *profound change*. Our *bodies* are no longer our silent and obedient companions. Instead they become troublesome and rebellious, unknown and threatening. We find ourselves forced to pay attention to our body in a way that is full of worry and we have physical pain that is at times very intense, or pain that invades everything.

Illness gives us an experience of our *own frailty*.

It also strikes our *relationships and communication* with other people: our families, our friends, our work… this feeling of dependence profoundly changes our relationships and often causes us great affliction and suffering.

Illness creates a great inner silence from which spring thoughts, feelings and *questions* that search for a reason for what has happened but to which it is not easy to give an answer: why has this happened to me? Why this illness? Why now?

Illness and death constitute a *singular* experience that afflicts what is most intimate and sacred in a person. They belong to the *limit situations of life* that make us touch the bottom, make us encounter the truth of ourselves, of other people and of God.

The experience of illness and death *challenges our freedom and severely tests our faith*: it can destroy us or help us to grow and to mature, to bend in on ourselves or to open ourselves more deeply to other people, to distance ourselves form God or to draw near to Him and to purify the image that we have of Him. In our hands there is the gift and the task of living our illness well or badly, transforming it into generous wine and not vinegar, drawing from its bitter flowers – as Antonio Machado says in his poem 86 of *Soledades* – a white wax as the bees do, so that it becomes a time of grace for us and for others.

It is not easy to live illness and death in a human way. And it is not easy to live faith in illness and death either. But it is possible and this is demonstrated to us by the testimony of so many priests that we have known and that we know and of those to whom I will only refer briefly. To all of them goes my gratitude and may the Father be praised who works so many wonders in those children of His who place trust in His hands.

'How difficult it is', writes *Fr. Congar*, 'to put faith and hope (during illness) into practice when there is nothing else, when daily bread becomes hard for us, without butter or jam! The difficult thing is to hope and believe when one has nothing. One day things will be filled with light. Then we will see their meaning when we were living them during the night. And then without doubt we will discover that in the final analysis the test was short-lived and it will burden us to have doubted for one moment alone, to have longed for evidence or a solution and thus to have wanted to leave faith and hope. On the contrary! The memory of having been solidly supported in faith will leave with us a taste of incredible sweetness that will end in an action of grace'.[1]

'Losing my health', says *Edilio Mosteo* of Saragozza, 'allowed me to engage in a vital rediscovery of faith. It was like a rebirth of something that was inside me, or expressed better, of Someone who dwelt in me. With Jacob, once again, I feel led to confess, with a cry, on the stone of my illness: 'Certainly, the Lord is in this place and I did not know it!' The Lord took advantage of my illness, granting me the prayer of the Psalm: 'You will teach me the pathway of life'. Where it seemed that everything was finishing, a new pathway, a new life, was beginning, His work, in which I cooperated with a great deal of difficulty, at times in an inopportune and at times in a bad way… Beginning with illness, with suffering, one also sees God in another way. Sick people provide us with a privileged and far sighted outlook on the mystery of God, His infinite beauty, even if beginning with His absence'.[2]

'Many times', wrote Miguel, a priest of Tenerife, who was ill with cancer, 'I have thanked God for my illness. Because He took advantage of the presence of Christ in my life to encourage other sick people and even the faith of other healthy people. I was very impressed when one morning they brought me some young people that I did not know who said to me: "the teacher of religion spoke of the fact that faith in Jesus Christ is able to preserve serenity in a person threatened by cancer and we have come to become aware of this". What pleasant moments I spent with them! I saw on their faces the impact that produced something that is not frequent. I said to them: "It is true, it is true… What in our lessons they told us about faith in Jesus Christ is true. The fact is that we had not drawn near to him truly interested".[3]

'I try to evangelise as much as I can beginning with this sit-

uation', said *Maximino Barrero* a few days before his death. 'First I did it with my life, with my health, with my voice… now I do it with pain, welcoming, suffering… with these thousand ways by which one can evangelise from a hospital bed. I enjoy great peace. What I wish most is *to live and die in peace*. I am on the cross of Christ and with him I want to rise again. I am going through truly difficult moments but I am always full of peace and with an acceptance of the will of God'.[4]

'I experienced the fact', writes D. Javier Osés, 'that in that moment God is the deepest and most decisive help and that health for a Christian is something more than not being threatened by death and that our God, Creator and Father, is truly the God of Life. Knowing that specifically in these moments God wants to make the experience of His love felt more gave me a great deal of peace. I did not want anything, neither to pray nor to think nor to speak. Only a few spontaneous feelings connected with God, with my family, and with the staff that moved around the ward, emerged. It was sufficient for me to know that God loved me and that I had to allow Him to be a Father with me. My illness and long convalescence helped me to approach my life in a deeper way, to experience that illness and health are gifts of God, that illness reduces one's mood and that in life there are things that continue to be primary and there are things that are secondary or tertiary. God, His goodness and His kingdom, are of primary importance'.[5] 'His death was already drawing near', narrates Margarita, the sister of Javier Osés, 'and with a great deal of courage and serenity he told us that he was dying and he moved all of us by telling us that the most important moment of his life was arriving. He asked for a crucifix, he kissed it, and with a clear and steady voice thanked God for the family that he had had, for the fact that he was a Christian, because God had called him to the priesthood, and for having been the bishop of the diocese of Huesca: "I offer up my life for priests and for the citizens of Huesca. I thank you, Lord, for having carried me with you… I have great peace and joy. God is Love and Peace… Always search for God and His will. Live for Him. Be concerned about other people and allow life to go forward. My life has been in God. I have lived for Him and now He is taking me with Him. I am happy".[6]

'God', writes *Jesús Burgaleta*, 'is with man as he is; weak, limited, alone, abandoned; if such was not the case, we would be destroyed. God respects and loves the finitude of man with limits. God does not free man from being a man. He wants him to be a man. He helps him to be what he is. God became man and can be none other than the happy God with whom to be joyful, the suffering God with whom to suffer'.

God in illness can but love us by loving us and thus respect what we are. God does not only suffer with me in my pain – my pain is His pain. God walks down the whole of my pathway, His humanised pathway until death. My death also takes place in Him. God is in the extreme loneliness of my bed, not as a simple 'other' who dries my sweat, but as the most radical and intimate part of me. God sees this in my weakness. God embraces it in frailty even when one opens one's arms and one has the feeling that one is embracing nothing. Accepting the destruction of all the portrayals of God, even the most legitimate – Father – is the summit of faith, of love and of hope. God shows that He is God when one cannot grasp this in any way, and despite everything we give ourselves to Him with all our being. His word is silence, a great and deep silence that no sound can fill. God grants to me the possibility to live and to grow, even in pain. From God I ask for the same thing that He gives me and wants to give me: to be a person in sickness and in health. I ask Him to have communion with Him, with myself and with other people. May His will be done'.[7]

'Now', writes *Iñaki Kámara*', 'it falls to me to live the priesthood in this other situation. You will ask yourselves whether I am happy. I am not so misguided as to say that this experience makes me happy. It is true that it is a severe situation. Specifically in these moments and in a situation of this kind one cries out, with hesitant faith, as to why, and as a response one obtains a very deep silence… In the middle of this silence, gradually, with my stammering faith, I discover the response of God. God responds to me through my family which from the very first moment has been near to me to the full and with great naturalness, a great deal of affection and optimism during their ups and downs. He responds to me through my companions and friends that come to visit me, and the many Cyreneans and Veronicas who day after day look after me, clean me, comb my hair, wash me and put me to bed. I must thank – because they help me face up to this situation – both the nurses and those who work in the kitchen and maintenance, Fernando and Felix, who offer me not only their medical knowledge but also their friendship'.[8]

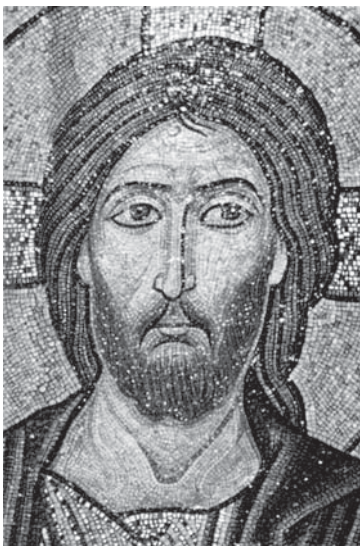
'I have the feeling', writes *D. Fernando Sebastián*, 'of not having been 'away from work' during this period but, rather, that the Lord wanted me to learn to serve in another way, beginning with weakness, with prayer and with suffering, really acknowledging the value of His grace and the superiority of others. During days of illness one prays more, one feels nearer to the presence of God who consoles us and strengthens us. The words of Paul become

clearer: 'My grace is enough for you'. 'The power of God is manifested in weakness'. Acceptance of one's own weakness helps one to give greater value to the possibility of other peoples and above all to the great force of the love of God which never disappears. Illness is a time of looking far ahead. One understands better the mystery of pain, the strength of love, the need for solidarity, the definitive wisdom of the cross of Christ, innocent love stressed in pain as a journey of freedom and salvation.

My experience was strengthened by the illness and the deaths of two friends and brothers who were very near to me – Bishop Conget and Bishop Osés. They reached the depths of this experience and entered by the narrow door of death to reach the glorious encounter with the God of love and life. We learnt from them how to die and live near to this God who awaits us with patience and mercy. We are weak but we will live and triumph thanks to the power of God present in Christ. He is with us until the end of time'.[9]

'Suffering', says *Fr. Häring*, 'liberated me a little from egocentricity. I engaged in a profound reflection on the paschal mystery, applying to myself what it says about the life, death and resurrection of Christ. In addition, I learnt to have trust in Providence: God does not leave me alone and does not allow me to doubt His presence, neither when faced with pain nor when faced with illness… nor when faced with death'.[10]

'As a Christian, as a religious and as a hospitaller', writes *Msgr. José Luis Redrado*, of the Hospitaller Order of St. John of God, 'I can confess that during my illness I saw God through very many 'human mediations', very many small and insignificant things that at other moments pass by unobserved. My illness helped me to trust God more and to contextualise many things that we seem to think are important but which in fact are not. Prayer is not easy, especially during the acute moments of an illness. My prayers were simple exclamations or phrases from the psalms. I felt the prayer of other people as I had never done before. They told me that they were praying for me, and I really felt this 'push', this 'force', and I thought: if men are so close to me, how can God not be?'



'By grace', wrote *José Luis Martín Descalzo*, 'I have always lived in faith and in love for God, and this was a 'normal' thing in my life. God was truly my father and Jesus was truly my friend and companion. During my illness I felt this fatherliness and this companionship to be even closer to me. Only the grace of God has been able to keep me happy in recent years. And I confess that I have experienced this almost as a hand that caressed me. God has never been absent from me at any moment. I know that it is not at all pleasant to be in the Garden of Olives, but at the same time there was no absence of 'angels who comforted me' as was the case with the Lord. Angels that at times expressed themselves simply through interior peace and at other times – many other times – were clothed as people who over these years have loved me and helped me a great deal. My brothers, my friends and a large number of people that I did not know supported me and I would regard as miraculous the fact that in the darkest hours there nearly always arrived a letter, a telephone call, a chance encounter in the street that helped me to recover my peace of mind. I must confess with joy in recent years that I have never felt so loved. And I would like to emphasise this because I very well know that many other sick people have never had the good fortune in this sense that I have had. A family, a sister at your side, are gifts that Providence has given me, but not all sick people find this.

I would not have been able to be ill without the example of Jesus. The good fortune that was mine in knowing his journey was without doubt the thing that most provided light during my illness. Thanks to him my illness illuminated my faith and at the same time my faith illuminated my illness. This illuminated my faith because it made it, perhaps for the first time, true. How easy it is to believe and preach when everything is going well! My pain allowed me to discover that I did not believe in many things that I thought I believed in.

But I should add that it was much more than faith that illuminated my illness… Discovering that beginning with my illness I took part in a more vital and truer way in the passion of Jesus for me was a primary source of hope and joy. I never asked God to heal me because it seemed to me to be an abuse of trust and above all because I feared that if God had taken away my illness He would have taken away one of the few good things that I had: the opportunity to cooperate with Him more intimately, more truly. I certainly asked Him to help me to bear my illness with joy and to help me take advantage of it and not ruin it through my selfishness and my need for affection. To be and love in the Garden is not a pleasure. Instead it is a gift, a present, at times the only one which at the end of life *I will be able to place in His hands as my Father*'.[11]

'Praying beginning with what I was experiencing', writes Antonio López Baeza – 'transformed my illness into a time of grace. A grace that the Lord granted me was to understand that the favour I asked Him and that He wanted to grant me involved above all else accepting the result of that process, whatever it might be,

as the thing that was best for me. To give life the same meaning or more meaning than before despite the loss of my faculties; to know that I can still be useful and work for other people; to accept the changes in meaning which the results force on me and to accept them without making of them a drama that embitters my existence and the existence of those who surround me… this was the most valuable miracle that the Lord wanted to grant me, or to express the point better, that has already been worked within me'.[12]

'The last three years', writes Cardinal Bernadin, 'have been a challenge for me in a way that has never occurred to me to keep my beliefs steady and to trust in the Lord. But my principal goal was to place my faith in action, to live according to the principles that direct my life. Above anything else, I want people to know that I am walking with them as a brother and as a friend. The decision to live my tumour in public was a decision to share a simple message: faith is truly important. Thank you for supporting me in the Lord, thank you for opening me to His will; I have been able to accept my illness and now my imminent death as well… Suffering and pain have lost meaning for me without God and my heart searches for people who feel abandoned or alone in their moments of greatest need.

I have been a priest for forty-three years and a bishop for twenty-nine years. I have always told other people to place themselves in the hands of the Lord. I have given advice to a large number of people who were addressing what I am addressing now. The moment for me has arrived to practise what I preach.

During this period I have prayed to God to grant me the grace to overcome my operation and the post-operation treatment with faith, without bitterness or undue worry. The special gift that God has given me is a gift of peace. In turn, my special gift to other people has been to share the peace of God with them, to help them to overcome their illness and their difficult moments. In speaking to them about my interior peace, I hope that people see that in prayer and faith there is much more than mere words. God in reality helps us to live fully even during the worst moments. And the capacity to do this depends on the depth of our relationship with Him through prayer.

During my convalescence the nights were particularly long, they were a time when various fears came to the surface. At times I was surprised to find myself weeping and this was something that rarely happened to me before… During those difficult moments, apart from faith and trust in the Lord, I was constantly sustained by awareness of the fact that thousands of people were praying for me…

It is clear that in the spring I will no longer be alive. But I will soon experience a new life in another way. Although I do not know what is awaiting me in the other life, I know that just as God called me to serve Him with all my abilities during the course of my life on earth, so now He is calling me home'.[13]

'The Lord visits me with the cross', said Cardinal Pironio. 'I have preached on the cross a great deal but how different it is to experience it and live it. I suffer a great deal but I am happy and at peace in the hands of a Father who loves me and in the heart of Mary my Mother… I want to live this moment of my life which the Lord has lovingly prepared for me. I am serenely ready to help in everything that the Lord wants to delineate along my pathway… Now the Lord calls from me the ministry of prayer and silence, the ministry of offering. It is more difficult but it is more fecund. The way I pray now is to suffer in silence and to offer up. I have offered up everything: for the Church, priests, consecrated life, the lay faithful, the Pope, the young, the redemption of the world… I believe that a few days of living remain to me. I had dreamed despite my illness that when this moment arrived I would have had time to read, to write, to withdraw to pray, to listen to people. But the Lord has lovingly disposed otherwise. I cannot see, I cannot move around, I cannot do anything. It is that after my service for the Church nothing remains for me to do. The end is drawing near. I suffer a great deal, I have great pain, but I do not want others to be aware of this because I do not want them to suffer as a result. Now I am only awaiting eternal life, and it will come in a few days. Despite my physical suffering, I am serene and tranquil. I am going to the house of the Father'.[14]

'Before receiving the anointing of the sick', said *Don Vechhi*, the High Rector of the Salesians, to the members of his General Council, 'I wish to express my trust in the Father. I want to abandon myself to He who has loved me with an eternal love. I am ready to accept His will. I express to Him my gratitude for what He arranged for me all the years of my life. In this time of illness I have had an opportunity to think anew about the situation of so many brothers who in my condition. I have experienced in the first person that to serve is a great thing and that it is painful to need to be served. I have reflected on the care which so many brothers and sisters have given me with so much delicacy. Not all my sick brothers receive the care that I do. I thank the Lord for this. I feel confused and glad at the same time because of the love that God has made grow in all those who live around me… I feel like a man who goes down a pathway between two wings of friends and inside me is spontaneously born the wish to proclaim with the psalm the joy of walking towards the house of the Lord to praise His name. I profoundly feel my membership of the Church and feel that she is truly accompanying me… My thanks go to everybody for everything that they have done… We always remain united in prayer. May God reward them and the Most Holy Mary bless them!'

'According to what Sister Maria Jesus who looked after him in hospital, Riccardo Alberdi asked to experience his death in his own way, a death

which he had already accepted. He took advantage of the day: reciting the rosary, reading, writing, and waiting for visits which tired him out. She saw that he was worried because in vast sectors of religious life a privatisation, a disassociation of faith, behaviour and commitment, was asserting itself. He asked to live for a little time more, despite the situation in which he lived, in order to help, from a wheelchair as well… those that were in need. He was frightened and worried about being able to reach a limit that would have impeded him from being courageous and he declared: my God, give me strength! And his gaze fixed on the crucifix. His illness was not easy to live through. His death was the creator of a spiritual reality of love'.[15]

'After this night of affliction', writes Joseph Breu, a missionary priest who died in Medellin in 1987, 'I want to pray and this prayer alone comes from me: 'to your hands Lord I entrust my spirit. Father, if you want, distance this chalice from me! However not my will but your will be done'. Rebellion, protest, strong rejection of what we live are feelings that flower and which we must express without fear. Only faith, the presence of the Lord, His strength, His love and the solidarity of other people help us to go forward. My activity is to abandon me to the hands of the good Lord who does not leave me and helps me at every moment. Illness is an experience that is a deep desert. One lives problems which in life I lived more intensely and in a deep sea of powerlessness, mixed with great confusion to obscurity. There remains abandonment to God in a powerless and dark faith. Illness undresses us, it makes us feel poor. Death can do nothing, anything, to life, it does not defeat it. Although I am dying, I feel life and today more than ever before I experience how death, illness, do not win; this cancer is not killing me, it undermines my physical health but not my life. Christ defeated death, I, too, am called to defeat death with my life'.[16]

'Lord, I ask you that in pain I will know how to ask you for the Spirit so that my life, in this pilgrimage which one day will finish, and my death, will be in your Cross. Hold my hand so that with you, despite the darkness of the journey, I will have the simple certainty of opening my eyes one day and seeing you at the right hand of the Father with the Holy Spirit'.

Many evenings, when sleep overcome me, I expected to meet you in the morning that had no end. But only you, Lord of my life and illness, know the day that will have no sunset. In the meantime, ensure that I do not leave you and that I thank you because every moment is a miracle while awaiting an even greater miracle: eternal life, living with you.

I abandon myself, sick and weak, to your hands, which made me, and to those of my brothers on my journey of pain who communicate your warmth to me. Your hands are full of mercy. In them I take refuge and I hide with all those who feel the proclamation that earthly life is the beginning of another life where illness and death will be defeated for ever.

Thank you, Lord of my life and my illness, because you have taught me that your grace is worth more than life, that the coldness of death will never allow the fire of your Love to die'.[17]

I will end this paper with poems written by three priests a short time before their deaths.

I am in your hands. My undone flesh
Continues to say: 'Love, what you want'.
Happy I consecrate to you my springs.
Happy I give you the peace of my annihilation.

This affection of my blood springs
From knowing that I am in your arms.
Dying is not dying, if you wait for me
At the end of this hard failure.

I am in your hands. With you I live.
With you I die. I am not a prisoner
Of groaning, at the doors of death.

Give me strength. Lord, for this leap
Where my love rises up high
And the earth is transformed into heaven.

Rafael Matesanz, priest of Segovia.

Something that is life of life
Is changing within me.
This life of mine is dying
And a new life is being born.

The castles of once upon a time
Are being transformed into ruins
There are creases in the tree
Because the tree is becoming old.

The words are shorter
And the silences are longer.
I walk down my path with calm.
And say my prayers with more calm.

Already many things weight upon me
And I am offloading a part of the burden
In my hours I live the urgency
Of repeating what I hold.

The empty furrow hurts me
And my wounds have opened
The sinning of sufficiency
And praising myself sincerely.

I am cleaning the terrain
Of leaves of mud.
The seeds of pines,
Of violets and rosemary.

To learn humility
And love for the littlest,
I will sow some bushes
Of violets in the centre.

To be 'the good fragrance of people',
The rosemary, and pines,
When they grow,
Will make me look at the sky more.

Something that is life of life
Is changing within me.
Is it already spring?
Has winter really gone?

Jesús Nieto, priest of Huelva

Testament of the Solitary Bird

IV *The Hopeful*

I know that I will lose my life.
But it does not matter.
I will go on, I continue playing.
And even though I know that I am breaking down
I will go on hoping, I continue hoping, I hope.

Where was my heart beforehand?
Where was the life that dawned whistling?
Where the happy teenager?
When did I change my soul into this garbage heap?

But I want to continue in this mill of hope,
Stubborn, obstinate!
Prepare my bill of indictment!

Perhaps one day the knot will be broken.
And if this does not happen it will be said:
'He was not able to. But he died at the gates of glory'.

First Presentiment of Death: VII

I lived playing at other things.
Living, dreaming, being a man.
At times one is born when one dies, but I ask myself
How are roses born, dreaming?

Give me your merciful hands
So that my heart is freed of the detritus.
Tell me if it is true that thinking of your name
Caterpillars become butterflies.

I know that heaven will open
And even more open will I find life.
We will no longer be prisoners.

We will win, losing the match.
And given that we have lived being dead,
Dying in the light we will become alive.

Last News on the Death of the Author: V

And so he saw the light, The light that came in
Through all the windows of his life.
He saw that pain hurried flight
And understood that death was not.

To die is only to die. Dying ends
Dying is a fleeting beacon fire.
It is to pass through a dying door
And finding there what was so looked for.

No longer weeping and asking questions;
Seeing Love without enigmas or waste;
Resting, living in tenderness

Having peace, light, home together
And finding oneself, leaving pain far off
The night light after the dark night

José Luis Martín Descalzo[18]

Rev. RUDESINDO DELGADO
Ecclesiastical Assistant of the PROSAC (Association of Christian Health-Care Workers), Spain

Notes

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[15] Department for Pastoral Care in Health of the Spanish Bishops' Conference, 'Vivir el morir', dossier photocopied in 1992.
[16] Department for Pastoral Care in Health of the Spanish Bishops' Conference, 'Vivir el morir', dossier photocopied in 1992.
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Human Resources in Catholic Health-Care Structures: What Sustainability for the Future?*

The Pontifical Council for Health Care Workers, in the form of its section for statistics and the collection of data, carried out a survey on 'human resources in Catholic health-care structures: what sustainability for the future' in order to learn about the questions and issues connected with the limited availability of human resources in Catholic health-care structures as well as about the activities and programmes within these structures.

This survey was begun at the beginning of 2006 in 121 countries belonging to the five continental areas of the world (Africa, America, Asia, Europe, Oceania) in which at that date at least one bishop responsible for pastoral care in health was present. Thus an information-gathering questionnaire was sent to 127[1] bishops responsible for pastoral care in health in these countries. These bishops in their turn then sent this questionnaire to the Catholic health-care structures active in their respective countries. In addition to these bishops, the Pontifical Council also sent this questionnaire directly to the three major Orders that work specifically in the world of health care, namely the Fatebenefratelli, the Camillians and the Hospital Sisters of the Sacred Heart of Jesus, with an invitation to have it filled in by their health-care structures in the five continents of the world.

The strategy of sampling that was followed was of the snowball kind, that is to say the approach was to create a non-probablistic sample. This is a sampling technique that most of the time allows the achievement of satisfactory results (although ones that cannot be generalised to all the Catholic realities working in the world), in a logic, obviously enough, involving an exploration of the various subjects of research. This technique often allowed the acquisition of information that was extremely useful for gaining knowledge about the contexts in which Catholic health-care realities work every day.

We thank the following for their valuable cooperation: the apostolic nuncios, who allowed connections with the bishops of the offices responsible for pastoral care in health; the bishops responsible for pastoral care in health who offered their help during the preliminary stage of the survey by identifying the most representative Catholic health-care centres in their countries; and the religious Orders and all those responsible for Catholic health-care centres who with efficiency and care filled in the questionnaire allowing us thereby to learn about the very many aspects of their service to suffering sick people.

Lastly, it should be made clear that this document does not seek to describe the whole of the work of the Church in the field of health and health care but it does allow us to learn about the contexts in which Catholic health-care realities work, the questions and issues that they have to address, as well as their daily commitment of an overall character to the person.

Premiss

The realities of the Catholic world working in the field of health care are many in number. The data of the Office for Statistics of the Vatican City on 31 December 2005 identified 5,246 Catholic hospitals in the five continents of the world; 17,224 clinics; and a flow of patients treated or admitted numbering respectively 184,810,687 and 84,098,396.

Given the evident reality of the capillary presence and action of the Church in the health-care field in the world, an attempt was made to produce a study that focused on the question of the human resources that are available, at least in relation to some of these realities.

138 duly filled-in questionnaires were sent in to the Pontifical Council by Catholic health-care structures working in the following countries:

Australia
Burundi
Chad
Colombia
Korea
Ecuador
Ethiopia
France
Ghana
Guatemala
Iraq
Ireland
Mauritius
Italy
Mexico
Nigeria
New Zealand
Papua New Guinea
Portugal
The Czech Republic
The Dominican Republic
Spain
Thailand
Turkey
Uganda
Zimbabwe

Number of Catholic hospitals and clinics; number of patients treated or admitted by continental area of belonging as of 31 December 2005

Continental areas	Number of Centres	
	Hospital	*Clinics*
Africa	1,046	5,292
America	1,712	5,363
Asia	1,073	3,626
Europe	1,257	2,755
Oceania	158	494
Total	*5,246*	*17,530*

Source: *Annuario Statistico della Chiesa 2005*, Libreria Editrice Vaticana.

* Descriptive report on the result of a survey carried out by the Pontifical Council for Health Care Workers.

Descriptive Analysis of the Data

TABLE 1

At the present stage of research, the structures on which we have data are distributed equally between developing countries and advantaged countries (developing countries – 50%).

TABLE 2

The structures that filled in the questionnaire were largely hospitals but they also have the role of being dispensaries (28% and 27%); residential centres (15%); clinics and consultancy centres (11.8%)

The Most Frequent Pathologies in the Year 2005

On average over 28% of patients of the Catholic health-care structures which filled in the questionnaire have problems connected with infectious or parasite-related illnesses; 25.5% have mental problems and behaviour disturbance; 13.4% suffer from respiratory illnesses; and 10.3% have problems connected with the results of congenital malformations and chromosome anomalies.

Tab. 1. Continental area of belonging of the country in which the structures were located

Continental areas	*Abs. val.*	*Val. %*
America	32	35.6
Africa	18	20.0
Asia	27	30.0
Europe	10	11.1
Oceania	3	3.3
Total	*90*	*100.0*

Tab. 2. Typology of the structures contacted (multiple answers)

Typology of structure	Answers		*% of valid cases*
	Abs. values	*% of answers*	
Hospital	45	28.0%	52.3%
Clinic	19	11.8%	22.1%
Dispensary	43	26.7%	50.0%
Residential structure	24	14.9%	27.9%
Semi-residential structure	11	6.8%	12.8%
Consultancy centre	19	11.8%	22.1%
Total	*161*	*100,0%*	*187.2%*

Valid cases: 86

Naturally enough, there are significant differences in the typology of problems that the centres have to address given the various contexts in which they work. However, it is interesting to observe that the percentages of some pathologies such as, for example, infectious and parasite-related illnesses and those connected with the digestive system present similarities in the same latitudes of the world. Indeed, one is dealing here with illnesses that affect population bands that live in conditions of grave poverty, with which are connected poor conditions of hygiene and inadequacy at the level of diet. These are the illnesses of the poor, evident signs of the condition of the grave poverty of the populations with which Catholic health-care structures are more likely to come into contact.

TABLE 3

Tab. 3. Sources of funding in 2005 (multiple answers)

Typology of sources of funding by economic macroarea	*Abs.val.*	*% of answers*	*% of cases*
Area of development* *Sources of funding*			
Public funds	17	14.4%	38.6%
Funds from public agencies	9	7.7%	20.5%
Donations from individuals	16	13.7%	36.4%
International bodies	7	6.0%	15.9%
Catholic NGOs	12	10.3%	27.3%
Non-Catholic NGOs	5	4.3%	11.4%
Patients and their families	27	23.1%	61.4%
Other sources of funding	24	20.5%	54.5%
Total	117	100.0%	265.9%
Developing areas ** *Sources of funding*			
Public funds	10	11.1%	24.4%
Funds from public agencies	3	3.3%	7.3%
Donations from individuals	13	14.4%	31.7%
International bodies	6	6.7%	14.6%
Catholic NGOs	9	10.0%	22.0%
Non-Catholic NGOs	2	2.2%	4.9%
Patients and their families	27	30.0%	65.9%
Other sources of funding	20	22.2%	48.8%
Total	90	100.0%	219,5%

* Valid cases 44 ** Valid cases 41

Tab. 4. Criteria utilised in the allocation of resources in the sphere of planning of the structures that filled in the questionnaire by macro-economic area (multiple answers) for 2005

Criteria for the allocation of resources by macroeconomic area	*Abs. values*	*% of answers*	*% of cases*
Developed areas* *Criteria for the allocation of resources*			
Cost/benefit	20	29.4%	54.1%
Cost/life expectancy	2	2.9%	5.4%
Cost/improvement of quality of life	24	35.3%	64.9%
Solidarity/subsidiarity	21	30.9%	56.8%
Other criteria	1	1.5%	2.7%
Total	*68*	*100.0%*	*183.8%*
Developing areas** *Criteria for the allocation of resources*			
Cost/benefit	22	35.5%	57.9%
Cost/life expectancy	7	11.3%	18.4%
Cost/improvement of quality of life	28	45.2%	73.7%
Solidarity/subsidiarity	4	6.5%	10.5%
Other criteria	1	1.6%	2.6%
Total	*62*	*100.0%*	*163,2%*

* Valid cases 37 ** Valid cases 38

A study of the sources of funding on which is based the economic sustainability of the Catholic health-care structures which answered the questionnaire is interesting if one considers the differences between the centres that work in developed countries and those in developing countries. The structures in the developing countries have greater difficulty at the level of access to sources of public funding than is the case with those in developed countries (14% of the answers of the developing countries compared to 22% in the case of developed countries). It is more likely, even though slightly so, that they receive donations from private individuals (14.4% of the answers from the developing countries as opposed to 13.7% in the case of developed countries). Lastly, it is not of secondary importance to observe that specifically in the poorest countries Catholic health-care structures receive greater support from patients and their families (30% of answers in developing countries as opposed to 23.1% in developed countries). This fact is very important because it stresses the nearness of the relationship that is installed between Catholic health-care structures and the populations that turn to them. Their economic support constitutes an indirect indicator of the level of satisfaction of the users who pass through these centres as regards the work of care and assistance that is provided within them.

Tab. 5. The most urgent problems in the management and organisation of the structures that filled in the questionnaire which are said to need immediate action

Most urgent problems	Answers		*% of cases*
	Abs. values	*% of answers*	
Lack of networks for connection	27	17.5%	38.6%
Lack of Catholic health-care personnel	19	12.3%	27.1%
Lack of funds to support the health-care structures	**51**	**33.1%**	**72.9%**
Difficulty in formulating training projects	27	17.5%	38.6%
Inability to perform specific roles in pastoral care in health	7	4.5%	10.0%
Local health-care emergency	23	14.9%	32.9%
Total	*154*	*100.0%*	*220.0%*

Valid cases 70

TABLE 4

But what are the criteria that govern the administrators of Catholic health-care structures in the allocation of available resources? In both developed and developing countries the prevalent criterion is that which relates costs to improvement in quality of life (35.3% of answers in developed countries and 45.2% in developing countries). This is a criterion that seems to go in the direction indicated years ago by the WHO when during a famous campaign of sensitisation it upheld the need *to add life to years and not years to life*, with an evident reference to the importance of improving the quality of life of the population of the whole of the world. From these data, quality of life would appear to constitute the centre of the planning of structures that work in the most deprived areas and in the richest ones. However, there do not fail to be differences which emerge when one analyses the further criteria which are subsequently taken into consideration. Indeed, whereas in developing countries the criterion subsequently adopted is that which relates costs to benefits in treatment (35.5% of answers), in developed countries the criterion of solidarity/subsidiarity is established (30.9% of answers).

TABLE 5

At this point we could but ask ourselves what the most problems to be addressed were in the sphere of the management and organisation of Catholic health-care structures. The question which had the greatest concentration of answers was 'lack of financial resources' (33.1% of answers given by 73% of the answering structures). This brings out critical economic condition which cannot but have consequences for personnel, thereby generating a sense of uncertainty which provokes dissatisfaction and de-motivation. Only subsequently, and a few percentage points distant, do the problems of adequate networks for connection with other local realities and difficulties in formulating training projects appear.

Health-care personnel

TABLE 6

This table brings out the fact that in Catholic health-care structures there are multiple professional specialist figures not only in the medical disciplines but also in other disciplinary areas, thereby achieving more overall care and treatment for suffering people. Medical and nursing figures predominate without, however, in assessing the personnel available, the heads of the structures who filled in the questionnaire stressing the insufficient numbers of nurses and other professional support figures such as psychologists, rehabilitation therapists, social assistants, sociologists, counsellors and caregivers.

TABLE 7

In this survey of the Pontifical Council we tried to explore certain aspects of the work load of people working in these structures. To this end, the structures that answered the questionnaire were asked which professional figures most often continued their service outside the working hours envisaged by their contracts. 67 structures out of 90 answered this question and pointed to nurses as the professional figures who most often provided service outside their normal working hours (21.8% of the answers). They were followed by administrative staff (21.4% of the answers) and medical staff (19.2% of the answers). These data as well seem to confirm the fact that the scarcity of nursing staff not only leads to a greater rigidity in conditions of work for these figures but also leads to excessive work which can only have consequences for their levels of satisfaction and motivation as regards their work.

TABLE 8 AND 9

Tab. 6. Human resources available in the Catholic health-care structures that filled in the questionnaire Year: 2005 (multiple answers)

Professional figures available	Answers		% of cases
	Abs. values	*% of answers*	
Doctors	74	9.9%	85.1%
Psychologists	50	6.7%	57.5%
Sociologists	25	3.3%	28.7%
Rehabilitation therapists	50	6.7%	57.5%
Professional educators	33	4.4%	37.9%
Social assistants	42	5.6%	48.3%
Nurses	78	10.4%	89.7%
Auxiliary technical workers	55	7.3%	63.2%
Auxiliaries	71	9.5%	81.6%
Administrative workers	70	9.3%	80.5%
Volunteers	54	7.2%	62.1%
Chaplains	55	7.3%	63.2%
Men or women religious	66	8.8%	75.9%
Caregivers, councellors	28	3.7%	32.2%
Total	*751*	*100.0%*	*863.2%*

Tab. 7. Personnel who work outside working hours. Year: 2005 (multiple answers)

Personnel who work outside working hours	Answers		% of cases
	Abs. values	*% of answers*	
Medical staff	45	19.2%	67.2%
Nursing staff	51	21.8%	76.1%
Auxiliary staff	44	18.8%	65.7%
Administrative	50	21.4%	74.6%
Staff of the pastoral service	44	18.8%	65.7%
Total	*234*	*100.0%*	*349.3%*

Valid cases 67

Tab. 8. Episodes of absenteeism. Year: 2005

Occurence of episodes of absenteism		*Abs. values*	*Val. %*
	YES	46	52.3
	NO	42	47.7
Total		*88*	*100.0*
Absent cases	No answer	2	
Total		*90*	

Tab. 9. Frequency of cases of absenteeism in the year 2005

Frequency of episodes of absenteism		*Abs. values*	*Val. %*	*% accumulated*
	Rarely	17	36.2	36.2
	Sometimes	22	46.8	83.0
	Often	6	12.8	95.7
	Always	1	4.3	100.0
Total		*46*	*100.0*	
Absent cases	Not applicable	44		
Total		*90*		

Excessive work, like a low level of flexibility in working hours, may be only one of the reasons why over a half of the structures that filled in the questionnaire in 2005 registered cases of absenteeism (52.3%). However, the phenomenon seems to be still characterised by its occasional character and does not constitute, at least for the moment, a 'pathology' of the system. 83% of centres declared that they had experienced only a few cases of absenteeism. Only in 17% of cases were their frequently recurring episodes (cf. tab. 9).

TABLE 10

In order to understand whether the economic-financial difficulties of Catholic health-care structures could influence behaviour involving absenteeism, those filling in the questionnaire were asked if during the year 2005 moments of financial difficulty had occurred leading to personnel not receiving their salaries on a regular basis. Only 12 structures out of 90 declared that they had had this kind of problem and whatever the case it had taken place only rarely. This fact would appear to confirm, and the use of the conditional tense is obligatory, that the possible reasons for absenteeism are to be found elsewhere.

TABLE 11

An interesting fact which should be commented upon as regards positive initiatives to support the human resources employed in the health-care world is the adoption of incentives. At least 57 structures out of 90 declared that they had adopted measures of this kind, above all for medical and nursing staff (respectively 22.5% and 22% of answers given by 80% of the structures). These groups were followed by auxiliary and administrative workers. However, the system of incentives would appear to be a transversal measure adopted in a generalised way for health-care workers (each structure, indeed, answered on average 3.5 options from those indicated).

Tab. 10. Moments of financial difficulty because of which personnel did not receive their salaries on a regular basis. Year: 2005

Irregular payment of salaries		*Abs.values*	*Val. %*
	YES	13	14.1
	NO	73	85.9
Total		*86*	*100.0*
Absent cases	No answer	4	
Total		*90*	

Tab. 11. Incentives for the payment of personnel. Year: 2005 (multiple answers)

Typology of incentives	Answers		% of cases
	Abs. values	*% of answers*	
Incentives for doctors	45	22.5%	78.9%
Incentives for nurses	44	22.0%	77.2%
Incentives for auxiliaries	42	21.0%	73.7%
Incentives for administrators	40	20.0%	70.2%
Incentives for the pastoral service	29	14.5%	50.9%
Totale	*200*	*100.0%*	*350.9%*

Valid cases 57

Tab. 12. Typology of formulas for contracts for personnel. Year: 2005 (multiple answers)

Typology of forms of contract	Answers		% of cases
	Abs. values	*% of answers*	
Full-time permanent contract	70	42.4%	94.6%
Part-time permanent contract	28	17.0%	37.8%
Full-time temporary contract	41	24.8%	55.4%
Part-time temporary contract	24	14.5%	32.4%
Consultancy/project	2	1.2%	2.7%
Total	*165*	*100.0%*	*223.0%*

Valid cases 74

TABLE 12

But what are the formulas for contracts that govern the work relationship between these professional figures and the Catholic health-care structures to which they belong? 74 structures out of 90 answered this question and declared that the full-time permanent contract was the most widespread form of contract (42.4% of answers given by 96.4% of those who filled in the questionnaire). If one then considers part-time permanent contracts it is possible to observe that two-thirds of personnel in Catholic health-care structures are permanent staff. This is a very important fact if one considers the increasing spread in the contemporary labour market of temporary contracts and project contracts, which are also of a temporary character. This fact can be read in two different ways: as an indicator of a decision to place the value of investing in human resources at the centre of things, and as an ineluctable element which should however be flanked by policies involving flexibility in work which allow objective difficulties of an economic character to be addressed. For this reason, permanent contracts are followed by temporary contracts (40%), either full-time (24.8% of answers) or part-time, and project contracts.

TABLE 13

In order to explore the real existence of conditions of flexibility in the management of overall working hours, those filling in the questionnaire were asked to indicate the professional figures for whom their contracts envisage an organisation of their working hours in line with their family needs. Only 36 Catholic health-care structures out of 90 (a little

Tab. 13. Professional figures for whom is envisaged an organisation of their working hours in line with the needs of their family lives within the context of the overall hours of their contracts. Year: 2005 (multiple answers)

Personnel for whom is envisaged an organisation of their working hours in line with the needs of their family	Answers		% of cases
	Abs. values	*% of answers*	
Medical staff	26	23.6%	72.2%
Nursing staff	20	18.2%	55.6%
Auxiliary staff	21	19.1%	58.3%
Administrative staff	20	18.2%	55.6%
Pastoral staff	23	20.9%	63.9%
Total	*110*	*100.0%*	*305.6%*

Valid cases 36

Tab. 14. Structures to which in 2005 personnel who had made a formal request were transferred (multiple answers)

Structures to which personnel made a formal request to transfer	Answers		% of cases
	Abs. values	*% of answers*	
To a public structure	13	21.7%	56.5%
To a private structure	18	30.0%	78.3%
To a structure in the same city	8	13.3%	34.8%
To a structure in another city	13	21.7%	56.5%
To a structure in another country	8	13.3%	34.8%
Total	*60*	*100.0%*	*260.9%*

Valid cases 23

Tab. 15. Principal motivations expressed in the requests for transfer to other health-care structures. Year: 2005 (multiple answers)

Motivations for requests for transfer	Answer		% of cases
	Abs. values	*% of answers*	
To move closer to home	6	12.8%	19.4%
To improve economic status	14	29.8%	45.2%
To join one's family	11	23.4%	35.5%
To go to a larger structure	10	21.3%	32.3%
Because of burn out stress	3	6.4%	9.7%
Mobbing	3	6.4%	9.7%
Total	*47*	*100.0%*	*151.6%*

Valid cases 31

Tab. 16. Principal reasons for the resignation of health-care personnel in the health-care structures that filled in the questionnaire

Reasons for resigning	Answer		% of cases
	Abs. values	*% of answers*	
To go to a larger structure	21	30.4%	52.5%
Because of burn-out stress	9	13.0%	22.5%
Because of a lack of economic incentives	13	18.8%	32.5%
For health reasons	15	21.7%	37.5%
Because of family problems	11	15.9%	27.5%
Total	*69*	*100.0%*	*172.5%*

Valid cases 40

more than a third) answered this question and they called attention to a greater flexibility in the contracts of medical staff (23.6% of the answers given by those who filled in the questionnaire), followed by those working in the pastoral service (20.9% of answers). A lower level of flexibility is to be found in relation to the professional figures of the nursing and administrative sectors. This fact is in line with the fact that there is a shortage of nursing staff. This shortage has consequences for conditions of flexibility as regards their work.

TABLE 14

About 30 out of 90 Catholic health-care structures declared that they had received during the course of the year 2005 requests to be transferred by their staff in order to go to private structures (30% of answers given by about 80% of cases). It is worthwhile, therefore, trying to understand the reasons for these requests. From table 15 one can see that the principal motivation is specifically of an economic character. 30% of answers provided by the structures who filled in the questionnaire, indeed, referred to the 'need to improve the person's economic position' as being the principal reason adopted to explain the request for transfer. Side by side with this reason there is also that of wanting to belong to a larger structure and probably one with more stability and security. There are also reasons linked to the need to be near a person's family. There are few examples of this but they nonetheless indicate a need for work mobility in this sphere.

TABLES 15 AND 16

Although transfers were declared by only about thirty of Catholic health-care structures, resignations by members of the personnel were indicated by forty. In this case as well one could only ask about the principal reasons for this decision. Staff chose to resign in order to move to larger structures (and thus one that were more solid in financial terms) (30.45 of an-

swers) and because of a lack of sufficient economic incentives (18.8% of the answers). It has already been observed that Catholic health-care structures envisage incentives at the level of pay for certain professional figures but perhaps this is not yet sufficient to meet the expectations of their staff. And then there are reasons based on health and family ties.

Training

TABLES 17, 18 AND 19

Without any doubt, training constitutes a dimension to which the administrations of Catholic health-care structures attribute importance. In 78 out of 90 structures regular courses for professional updating and training are provided. This orientation confirms the intention of these structures to invest in their own personnel, supporting them and improving their professional skill and expertise, and this has positive consequences in terms of the performance of services. It has already been emphasised that economic support provided by patients and the families of patients constitutes an indicator of the success of the medical service in a broad sense provided by these structures.

Almost 60% of courses took place with a frequency of at least every three months, the other 40% with a frequency of one a year (cf. tab 18), in the form of residential courses (35.5% of the answers) and seminars (32.9% of answers) (cf. tab 19).

TABLE 20

The subject area most addressed in these courses is health-care information and communication technology (19.2% of answers given by 60% of cases). This is an aspect of especial importance which deserves a brief comment. The emphasis placed on this subject indicates the presence of a culture that places information at the centre of health-care planning. We live in a society of information and technological innovation. The fact that Catholic health-care structures invest in this area is a symptom of the rooting of an information culture from which a good organisation and management of resources, especially if these last are limited, cannot depart. Sensitivity to the use of information and communications technology was also confirmed by the success that the use of the computerised questionnaire had in the carrying out of the survey, above all in the poorest countries.

These courses were followed by courses in health-care education (18.3% of answers), on hospital management and administration (17.5% of an-

Tab. 17. Structures in which during 2005 were organised professional up-dating and training courses for the medical/health-care staff

Organisation of professional updating and training courses		*Abs. values*	*Val. %*
YES		78	87,6
NO		11	12,4
Total		*89*	*100,0*
Absent cases	no answer	1	
Total		*90*	

Tab. 18. Frequency with which these courses were organised in the year 2005

Frequency with which the courses were organised	*Abs. values*	*Val. %*	*% accumulated*
Once a year	14	18,4	18,4
Twice a year	17	22,4	40,8
Once every three months	17	22,4	63,2
At least once a months	28	36,8	100,0
Total	*76*	*100,0*	
Absent cases			
not applicable	12		
no answer	2		
Total	14		
Total	*90*		

Tab. 19. Typology of organisation of the courses. Year: 2005 (multiple answers)

Typology of courses	Answers		*% of cases*
	Abs. values	*% of answers*	
Seminars	51	32,9%	67,1%
Conferences	49	31,6%	64,5%
Residential courses	55	35,5%	72,4%
Total	*155*	*100,0%*	*203,9%*

Valid cases 76

Tab. 20. Subject areas addressed in courses involving the professional training and updating of personnel. Year: 2005 (multiple answers)

Subjects areas of the courses	Answers		*% of cases*
	Abs. values	*% of answers*	
Ethics and bioethics	39	17,0%	52,7%
Pastoral care	36	15,7%	48,6%
Health-care information and communication technology	44	19,2%	59,5%
Health-care education	42	18,3%	56,8%
Management and administration	40	17,5%	54,1%
Pharmacological updating	28	12,2%	37,8%
Total	*229*	*100,0%*	*309,5%*

Valid cases 74

swers), on the subjects of medical ethics and bioethics (17% of answers), and on pastoral activity (15.7% of answers).

Final Observations

1. In order to establish a framework of reference involving values, we have to have a summarising approach to the major subjects dealt with by the survey connected with the most urgent contemporary problems in order to understand the conditions of mission of Catholic health care, the situation of the personnel in order to identify the function of their sense of belonging, and, lastly, activity involving training in order to illuminate the preferences in decisions regarding choices. In a reading of these observations one should also bear in mind that the survey was carried out on the basis of a sample and did not involve all Catholic health-care structures.

2. As can be deduced from table 5, the problem that should be addressed as an epochal emergency is the financial shortfalls in supporting these health-care structures. We should see this fact as the joint result of the progressive thinning of traditional flows of charity towards developing countries and the contemporary weakening of the local financial resources allocated to health care in socio-economic contexts of deterioration and underdevelopment. Even though the absence of networks of connection is not seen as an emergency, it would be advisable to place at the centre of the Church as regards health care the subject of subsidiarity in order to allow a re-foundation of the Catholic presence in the world of health and health care. Without forgetting that in a situation of economic uncertainty health-care professionals themselves are afflicted by dissatisfaction and de-motivation.

3. In tables 7 to 16 one can clearly see that it is difficult to engender confidence in the health-care professionals employed in Catholic structures because of the fact there is often a lack of hope about the future. In table 14, in particular, one can see that 30 structures out of 90 had received requests for new postings by their personnel to go to other structures and in table 15 one can see that the principal reason for this is of an economic character. This situation makes difficult both the defence of the Catholic identity of a structure and the services that are offered, and also impedes the maturing of laity who are able to take on tasks of active witness in pastoral care and in bioethics.

4. Specifically in the questions on training projects, one can see a certain imbalance between training of a technical character and training of an ethical-pastoral character. The subject most addressed in courses is health-care information and communications technology and although this consoles the promoters of a correct modernisation at the same time it imposes reflection about overall training strategies that cannot neglect the training that is necessary to ensure that Catholic health-care structures are ecclesial works of evangelisation. This apostolic requirement must place on the same level, at the least, technical training and humanistic training: these two intertwining and ethically harmonised realities must be the subject of initial training for every new worker and of permanent training for all workers. In particular, it is necessary to encourage courses in pastoral care in health which in most of the Catholic health-care structures of our sample are not very present.

5. The shortage of data on pastoral care in health simulates us not to neglect this reality but, instead, to point out the needs and programmes that are most suited to a more incisive mission. The evangelisation and the specific identity of a Catholic health-care structure cannot depart from a major reflection on man, on the meaning of suffering, and from the spiritual accompanying of patients. These are all aspects that pastoral care in health must assure. However, from the few data that are available to us we can see the difficulties that exist as regards the organisation of pastoral care as a service, given that in many structures of our sample it encounters obstacles in performing the roles that are allotted to it. The figures who work in pastoral care in health, that is to say chaplains, religious and secular people, albeit in their low numbers, assure a sufficient response to the needs of their structures, not least because most of the time they work outside working hours, and without receiving any economic payment as occurs with overtime in the other health-care professions, and this bears witness to love and a spirit of Christian charity towards those who suffer which still today, despite the very many difficulties, characterises this service.

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Note

[1] The number of bishops responsible for pastoral care in health is greater than the number of countries because in some of these countries there are two bishops who have this responsibility.

Hospitals as Settings for the Exploration and Practice of Hope*

This subject, 'hospitals as settings for the exploration and practice of hope', is at one and the same time delicate, complex and stimulating. At the level of principle, nothing can be objected to in this statement if we consider the kind of service that is involved, the conditions involved, and above all the activities that are usually engaged in. Indeed, this subject corresponds in a special way to the fundamental aspiration of contemporary man, as Msgr. Ignazio Sanna observes: 'Man is a historical being, anchored in the chain of the universal future, a being in completion, a being open to the future who looks for a fixed horizon of meanings, a stable nearness to happiness, a secure guarantee as regards life, love and interpersonal communion… Secularised society, which man sees from the window of his existence, offers him changing horizons of meaning, connected with work, with health, with well-being, with commitment to noble humanitarian ideals. It generates in him historical hopes of self-fulfilment and expands in him a wish for new consumption, which is increasingly demanding and radical. It also offers him attained achievements of liberation and human promotion which render aspiration to another life and another dimension superfluous. Lastly, it makes him forget death and the questions that are inevitably linked to death'.[1] However, when illness comes into play, together with its series of pains and sufferings, of fractures and questions about meaning that receive no reply, he then yearns for that necessary power, to quote Varillon, which requires human hope in order to be achieved.[2] Almost immediately, however, one sees the need for certain clarifications: what hospitals are we talking about and what kind of hope?

1. Which Hospitals?

There are various typologies of hospitals according to the classifications that are employed and the latitudes in which they are located. Each one of them in their own way can be a setting for the exploration and practice of hope. The problem is to verify the pertinence of the horizon of values of each hospital structure as well as the real existence of human and material means that correspond to the needs of people who turn to it. As Pier Luigi Marchesi observed a few years ago: 'One can use the Gospel, prayer and religious rules to distance oneself from men, to keep them under; science and technology when used to subject men threaten mankind. But one can use religious life, action, science and technology to foster the development of man, to protect him at moments of weakness, to assure that he has freedom, responsibility, and the desire to live as a man'.[3]

Even though difficulties, above all of an economic character, are not absent, it is well known that in the industrialised world it is the task of the state to assure its citizens good health and a suitable health service. In other parts of the world this happens relatively less or does not take place at all. This compromises the hope of innumerable human beings in the rest of the world.

From an ideological and cultural point of view, a distinction is usually made between Catholic hospitals and public hospitals. A Catholic hospital, like other health-care institutions of the Church, is 'a specific way by which the ecclesial community implements the mandate to 'heal the sick-'.[4] This was officially emphasised by the Servant of God, His Holiness John Paul II, of venerable memory, in his Motu Proprio *Dolentium Hominum* (11/02/1985), by which he created the Pontifical Commission for Pastoral Assistance to Health Care Workers which then became the Pontifical Council for Pastoral Assistance to Health Care Workers:[5] 'In fact, over the course of the centuries the Church has felt strongly that service to the sick and suffering is an integral part of her mission, and not only has she encouraged among Christians the blossoming of various works of mercy, but she has also established many religious institutions within her with the specific aim to fostering, organizing, improving and increasing help to the sick Missionaries, on their part, in carrying out the work of evangelization have constantly combined the preaching of the Good News with the help and care of the sick' (*DH*, n. 1). The service given to patients in every Catholic health-care structure should, therefore, be organised in a way that is in conformity with this mission.

In order to perform this role, in addition to the standards required by specific legislation, a Catholic hospital should have the following characteristics: the centrality of the sick person, overall care for the patient with attention being paid to all the dimensions of his or her person, the defence and promotion of unborn life, commitment to the rehabilitation of the disabled and qualified care for dying sick people, the training of personnel at a human, Christian and professional level, a prophetic presence in the most difficult and newest areas of medicine, quality and efficiency in the ministry of the spiritual and religious accompanying of the sick person and his or her family relatives, the safeguarding of humanity in care and services, and the promotion in the areas in which it operates of a health-care culture based on authentic human and Christian values. All of this should be achieved without neglecting a transparent and suitable administrative and economic management of the hospital, even though, as Cardinal F. Angelini

* Paper given by H.E. J.L. Redrado, O.H. during the series of meetings on the encyclical *Spe Salvi,* The Political Charity International Association, 8 october 2008

well observes, a Catholic hospital has 'the duty to act so that the human and spiritual budget' of its 'management has priority over the economic and administrative budget'.[6]

With respect to a public hospital, it should be pointed out tat this is the property of the state and it has a more juridical character in order to distinguish it from a religious hospital; as a state service, it is non-confessional and ethically pluralistic. Over the years, however, the attention that has been paid to legal and structural aspects has reduced to a minimum from a juridical point of view the differences between a Catholic hospital and a public hospital.[7] Both of them have to face up to the same problems of an economic, cultural and technical-scientific character.

2. Settings for Learning about and Practising Hope

The Holy Father Benedict XVI devotes the last part of the second encyclical letter *Spe Salvi* to settings for learning about and practising hope and he dwells upon three: *prayer* (nn. 32-4), *acting* and *suffering* (nn.35-40),and *judgement* (nn. 41-48). In these dense and wonderful pages, the Supreme Pontiff describes hope in terms of concentric and complementary circles (n. 35), that is the personal horizon, the social horizon and above all else the theological horizon, which includes the whole of the creation, in line with what St. Paul says in his letter to the Romans: 'For the creation waits with eager longing for the revealing of the sons of God… the creation itself will be set free from its bondage to decay and obtain the glorious liberty of the children of God' (Rm 8:18-21).

In this paper, of interest in a specific way is the tandem *acting/suffering* as settings for learning about and practising hope. *Acting* is this inasmuch as every human project is based upon it, supported by it, and receives its meaning from it. Hope, therefore, is a door that is open to the future and its horizon is the Love of God.

Suffering, too, observes the Holy Father, is a setting for learning about hope. It is this inasmuch as it creates an ineluctable experience of human life which it is not possible to eliminate despite the efforts and investments made in this direction. Suffering enters personal existence without knocking and blows up many human projects. In this way, suffering makes us experience the limits of our being and the limits of our action. Thus, Christian faith teaches us that the elimination of suffering, like the elimination of the sin and finitude which underlie it, can only be worked by God. We know now, thanks to Jesus, the Son of God made flesh, who suffered, died and rose again, that suffering can acquire a meaning and inspire praises to God, joy, and hope in the heart (nn. 36-37). In addition, for individuals as for societies, interaction with suffering and a suffering person determines the level of humanity when suffering is accepted and shared. For this to happen with individuals and societies, individuals should find in their own suffering and in the suffering of others a meaning, a pathway of purification, of maturation and of hope (n. 38). This principally means two things: the capacity to be-with those who suffer in loneliness, that is to say an aptitude for *comfort*, and the acceptance/bearing of suffering out of love for good, truth and justice.[8] Indeed, we should never forget that God participates in our suffering.

3. Can a Hospital be Seen as a Setting for Learning about and Practising Hope?

First of all we should understand what kind of hope should be explored in a hospital. At the beginning of section 35 of *Spe Salvi*, the Holy Father makes a distinction between small hopes and large hopes, according to the importance of the field they are applied to and the perspectives of the individuals who are their bearers – a task that concerns first of all an improvement in the condition of the individual and a contribution to the possible arrival of a better, more luminous and human world, which certainly do not have the same weight and significance. Now, hospital activity can correspond to two personal and social horizons whether one is dealing with service to an individual patient or activities involving medical-scientific research that seeks to solve a situation that involves millions of human beings.

By their nature, hospital activities, which involve medical-scientific research and the treatment of, and care for, sick people, fully belong to the horizons of acting and suffering. Indeed, a person who turns to a hospital service is a being in need whose life is threatened at its foundations by illness and the malaise that this illness causes.[9] He or she wants to get better, that is to say he or she wants to see the balance of his or her vital functions restored. He or she thus nourishes the hope that he or she will be able to overcome his or her current crisis and return to his or her normal life, daily activities, projects, etc.

But what kind of hope is this and on what is it based? In his encyclopaedic dictionary on the thought of St. Thomas Aquinas, Battista Mondin provides the following definition of hope: 'a feeling of confident expectation as regards the future'.[10] In this

article the author makes an important distinction between the concept of hope and the characteristics that define hope: 'there is both a simply human hope and a Christian hope: the first bases its confident expectation on human calculations and power; the second bases its confident expectation on the Word of God, on His promises, on His grace'.[11]

As regards the characteristics of the subject of hope, there are four: it must be a good; a future good; an arduous good; and lastly a possible good. This last distinguishes it in a fundamental way from the feeling that is close to it, namely desire, which 'concerns any good' and 'is directed towards any good, independently of the fact of being possible or impossible'.[12]

With respect to the various hospital activities of diagnosis, prognosis, treatment and care, these two forms of hope – human hope and Christian hope – are ideally present, at times contemporaneously, at times not, depending on whether who turns to a hospital service or provides it is a believer or not. Indeed, hope is imperatively requested by the good pursued both by the patient and by the medical doctor and involves a return of the balance and harmony of the vital functions, which have been compromised by illness. Sick people, like other individuals concerned with the achievement of this good, that is to say in various ways medical doctors, nurses, chaplains and voluntary workers, work, and in some ways hope, for the achievement of the results aspired to without further complications. Too often, unfortunately, this hope comes up against a complex, opposed and disappointing reality.

4. The Pathway of Hope in Health-Care and Hospital Structures Bristles with Permanent and Always Obstinate Difficulties

That no health-care system is ideal is a part of the nature of human affairs: no human work, in fact, is ever fully up to its conceptual model. This also and above all applies to hospital activities when compared to the strong hopes that they generate in beings who are frail and in need of medical care and treatment. Journalistic news has by now habituated us to the worries generated by what is termed 'bad health care', an unequivocal mirror of the difficulties of the existing health-care system, whatever it may actually be, in fulfilling its mission of guaranteeing good care and treatment to those people who turn to its services.[13] All of this takes us by surprise and leaves us amazed given that the same news constantly shows us the advances of medicine which are in constant and almost unlimited expansion thanks to the very great knowledge that exists in the various spheres of medical science and technology applied to the health-care medical sector.

The problems of the world of health care are not confined, obviously enough, to questions of ordinary corruption, blameworthy distraction or simply by evident incompetence at the level of diagnosis or treatment. Grave and chronic difficulties in obtaining sufficient economic and human resources also constitute a serious obstacle in the way of the development and the efficiency of national and international health-care systems and strongly condition them. Resort to the free market and to private investments in health care, the transformation of hospital structures into health-care companies, as well as the reduction in the number of such structures that work in local areas, all constitute a tangible and irrefutable testimony to these difficulties connected with budgeting.[14]

In addition, the difficulties of an ideological and cultural character should not in the least be underestimated because, as the Pastoral Note of the Episcopal Commission of the Italian Bishops' Conference for the Service of Charity and Health observes, 'the contemporary organisation of the world of health and health care should be understood in the light as well of certain trends of contemporary culture and scientific and technical progress that have affected the way in which health, illness, life and death are seen'.[15] One may think, for example, of the by now recurrent pushes towards abortion and euthanasia[16] which periodically animate the news, now and then generating major debate that at times leads on to somewhat permissive legislation that does not respect the complexity and the delicacy of human life.[17] Thus the horizon of hope, which is culturally wandering, at times is cloudy and uncertain. The bishops of Italy agree with this and expressed themselves in the following way in 2001: 'We wish to address a word of hope to everyone. Hope, today, is no easy thing. Its progressive reduction does not help us: the eschatological horizon has been obfuscated if not removed in our culture, like the idea that history has a direction that should be followed towards a fullness that goes beyond it'.[18]

A question that is not only cultural but also anthropological thus poses itself. Care for suffering man, in fact, is absolutely dependent on the idea that one has of man in general. If his horizon is only earthly, then care for a sick person can be limited to caring for his or her suffering part alone, thereby reducing him or her to one of his or her parts. Whereas if man is seen in his entirety, that is to say in relation to both his corporeal and psychological and spiritual dimensions, certainly the care that is provided to him will not stop only at his sick

part but will try, at least in tendency, to deal also with the health of other parts of him because the whole person falls sick and not just an organ of his. One may state, therefore, that from the concept of man follows the concept of health, of health care and of a hospital structure.

5. Catholic Health-Care Structures and Christian Hope

A Catholic hospital, and this should never be lost from sight, is not distinguished from other hospitals because of a particular architectonic structure, because of the name of the body that owns it, or even less because of the organisational forms of its various departments. It is fundamentally characterised, rather, by the spirit and the ethical-moral orientation that underlie the services that is provided to the sick people who turn to it. This was made clear by Cardinal Fiorenzo Angelini in his paper to the international conference on the identity of Catholic health-care institutions organised by the Pontifical Council for Health Care Workers and held in November 2002: 'As I have always argued, a hospital inasmuch as it is a Catholic hospital does not have a duty to be different from other hospitals or similar health-care structures; it is simply called to be or at least to try to be better than other because to follow Christ in providing care to those who suffer is to place at the service of the sick the utmost of one's professional skill and expertise with generous dedication, although, as John Paul II has written, however important and indispensable it may be 'no institution can on its own take the place of the human heart, human compassion, human love, human initiative, when it is a matter of coming to the help of the suffering of others' (*Salvifici doloris*, n. 29)'.[19]

Health-care structures, therefore, are instruments in the hands of health-care workers, and the same may be said of medical and nursing expertise, economic or technological resources, and the various social energies that act at the bedside of a patient: all of these must be placed at the service of the patient in homage to the mandate of the Lord to preach the Kingdom of God and heal the sick (Lk 9:2). Indeed, as Brother P. L. Marchesi observes: 'For a patient a hospital is not a bar, a cinema or a stadium; it is a place where one may not be treated well, where one can be neglected, where one can die'.[20] Hence the strong need for the humanisation of hospitals in order to make them a setting for hope because a person who is admitted is a person in a state of crisis, in a state of need that goes beyond the normal. He or she is a frail person inasmuch as the illness has made him or her lose control of his or her own body which at times no longer responds to stimuli and seems extraneous to him or her. But he or she is also a person assailed by a thousand questions about his or her falling ill, about the meaning of health and illness, of pain and of suffering, about the meaning of life and history, from the point of view of the personal aspects of fulfilment, daily activities, initiatives and hopes as well.[21]

The question about meaning, however, transcends the search for healing in a narrow sense because, as Prof. M. Petrini points out, 'Health in Christian thought is… inseparable from salvation and the newness and originality of Christianity lies in having introduced this concept of health that is compatible with a state of illness inasmuch as faith makes a person able to appreciate his or her own suffering'.[22]

The teachings and the pastoral practice of the Church down the centuries, as the Motu Proprio *Dolentium Hominum* of John Paul II quoted above observes, bear witness to the constant care and concern of its pastors, at various levels, in this area. This is how the Servant of God John Paul II expressed himself and on one occasion he pointed to its theological foundation: 'It is the Creator of the universe who shaped man and devised the origin of all things (2 Mac 7:23). Man, therefore, in all the expressions of his life belongs to God, to whom he must answer… for the use that he has made of the great gift that he received. There derives from this the nobility of medicine which by definition is at the service of human life. As such it involves an essential and inescapable reference to man in his spiritual and material wholeness, in his individual and social dimensions: medicine is at the service of man, of the whole man, of every man'.[23]

These are important words indeed: man, in all the expressions of his life, belongs to God. It is specifically this belonging to God that constitutes the foundation of Christian hope and disqualifies in a definitive way all forms of exaggerated treatment and all forms of euthanasia. Thus there is always hope, even for those who no longer expect anything from therapeutic medicine and for whom the only pharmaceutical that remains is humanity, as indeed Brother P.L. Marchesi observes when reflecting on the hospital-company and modernity: 'One can die of modernity declares a contemporary slogan. Instead, one lives through humanity, one hopes and one gets better. And when one cannot recover one dies in peace because humanity is not something that is good that should be performer paternalistically but rather it is a resource, an ability, which has a therapeutic value, it is a 'pharmaceutical', at times the best that the hospital has available to it'.[24]

This applies to those patients who have to coexist with an incurable illness[25] and to those patients for whom therapies have become ineffective and who need to be prepared to detach themselves from this world in order to draw near to the fatherly embrace of that merciful and loving God who so loved the world that he gave it His Son for its redemption (cf. Jn 3:17). In order to humanise hospitals and proclaim hope during this penultimate stage of life on earth, the Church must be certainly present with her caring with accompanying, with prayer and with the sacrament of the anointing of the sick. But doctors and those responsible for the care of the patient as well should not withdraw

when, powerless, they see the possibilities of a cure for their patient dissolve, because 'Even when 'nothing more can be done', there is still a great deal to be done. First and foremost the pain must be alleviated as much as possible. But there is also a work of care, support, comfort… Out of professional duty, the medical doctor implicitly commits himself to making the final time of his patient as comfortable as possible. Being of help to the dying in order to make possible a human passing over is a task which, beyond the medical doctor, also concerns those who work in the field of care. In a particular way it concerns the Christian community. It is the very logic of the Gospel that leads the disciples of Jesus to place at the centre of things those who are pushed to the margins by the logic of power. Those who are losing their lives are the poorest of the poor. The Church is a debtor to them for their service of hope'.[26]

I will end this paper with a quotation from the philosopher Martin Buber who tells us how the name of God is the last hope to be invoked during terrible moments of suffocating anxiety: 'Yes, God is the most overloaded word in the whole of human language. No other word has been so soiled and lacerated. Precisely for this reason I must not forgo it. Generations of men have off-loaded the weight of their afflicted lives onto this word and have stamped it into the ground; now it lies in the dust and bears all their burdens. Generations of men have lacerated this name with their division into religious parties; they have killed and died for this idea, and the name of God bears all their fingerprints and their blood. Where could I find a word that resembled it to refer to the Almighty?... Certainly men draw caricatures and write underneath 'God': they kill each other and do this 'in the name of God'. But when all illusions and deceptions disappear, when they are face to face in the deepest darkness and no longer say 'He, He' but sigh 'You, You' and implore 'You', they mean the same being, and when they add 'God' do they not invoke the true God, the only living God, the God of human creatures? Is it not He, perhaps, who listens to them? Who answers their prayers? Is not the word 'God' precisely for this reason the word of invocation, the word that became a Name, consecrated for all time in all human languages? We should esteem those who prohibit it because they are opposed to the wrong and the shameful abuse of those who so often appeal to 'God' to justify themselves; but we should not abandon it… we cannot remove all the stains from the word 'God' and we cannot leave it whole, but we can raise it up from the ground and, stained and lacerated as it is, raise it up above an hour of great pain'.[27]

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Notes

[1] SANNA I., *Chiamati per nome. Antropologia teologica* (San Paolo, Cinisello Balsamo (MI), 1994), pp. 382-383.

[2] The following text of Varillon is excellent: '*Sur terre, depuis qu'il y a des hommes, il y a de la religion, une « foison de religions » comme dit Pascal. De la religion ou di sacré. Instinctivement, en effet, l'homme cherche une "puissance" capable de réaliser son espérance. Au delà de ses besoins élémentaires, il éprouve le besoin de vivre plus intensément, plus librement, plus totalement. Il veut échapper à la précarité, à la fragilité de son existence, et du même coup à l'angoisse (la précarité engendre l'angoisse et l'angoisse engendre le désespoir).Ce que l'homme désire, consciemment ou non, c'est une intensité de vie sans limites, une plénitude d'existence sans failles. Ce que Nietzsche et Rimbaud appelleront "l'éternité", c'est-à-dire, la Béatitude*', VARILLON F., *Joie de croire, joie de vivre* (Le Centurion, Paris, 1981), p. 216.

[3] MARCHESI P.L., 'Umanizziamo l'ospedale', in MARCHESI P.L., SPINSANTI S., SPINELLI A., *Per un ospedale più umano* (Ed. Paoline, Cinisello Balsamo (MI), 1985), pp. 17-18.

[4] PETRINI M., 'Ospedale cattolico', in CINÀ G., LOCCI E., ROCCHETTA C., SANDRIN L., (eds.) *Dizionario di teologia pastorale sanitaria* (Edizioni Camilliane, Strada Santa Margherita (TO), 1997), p. 800.

[5] Cf GIOVANNI PAOLO II, *Costituzione Apostolica Pastor Bonus sulla Curia Romana,* nn. 152-153, (Tipografia Poliglotta Vaticana, 1988), p. 69. This teaching is echoed by Cardinal Fiorenzo Angelini, President Emeritus of the Pontifical Council for Health Care Workers: 'behind the objective meaning [of Catholic hospitals] there are centuries, even millennia, of a history of pastoral carein health, a salient expression of evangelisation': ANGELINI F., 'Primo approccio agli ospedali cattolici oggi', in *Dolentium Hominum*, 52 (2033/1), p.11.

[6] ANGELINI F., 'Primo approccio agli ospedali cattolici oggi', *Dolentium Hominum*, 52 (2033/1), p. 11.

[7] 'This specific identity has lost a great deal of its meaning given that most hospital institutions are state-owned and many religious hospitals, thank to the juridical peculiarity of the classified hospital, are in large part similar to state structures': S. LEONE, "Ospedale civile, in CINÀ G., LOCCI E., ROCCHETTA C., SANDRIN L., (eds.) *Dizionario di teologia pastorale sanitaria*, pp. 804-805.

[8] The Holy Father writes: 'Furthermore, the capacity to accept suffering for the sake of goodness, truth and justice is an essential criterion of humanity, because if my own well-being and safety are ultimately more important than truth and justice, then the power of the stronger prevails, then violence and untruth reign supreme. Truth and justice must stand above my comfort and physical well-being, or else my life itself becomes a lie' (n. 38).

[9] S. Leone writes: 'What in essential terms does being admitted to hospital mean? First of all to experience a state of need which is not connected with the ordinary needs of daily life… It is a sign of a pathology and thus of a frailty that could not otherwise be dealt with and thus it connotes an experience of finitude, which is perceived more the more it was distant from the existential horizon of the patient': LEONE S., 'Ospedale civile', in *loc. cit*,, p. 808; MINO J.-C., FRATTINI M.-O, FOURNIER E., 'Pour une médecine de l'incurable', in *Études*, 4086 (2008) 753-764.

[10] 'Hope is a spiritual force that affects man as man. It connotes man and distinguishes man from other beings like other goods such as reason, freedom, language, culture, religion etc. Hope is specific to the man-being because he i san incomplete being, in constant movement towards the future': MONDIN B., *Dizionario enciclopedico del pensiero di san Tommaso d'Aquino* (ESD, Bologna, 1991), p. 576.

[11] *IBID*.

[12] *IBID*., p. 577. The author makes clear that 'if one is dealing with hope as a theological virtue, its objective must be the supreme good, that is to say happiness or God and its achievement made possible by God and not some creature'.

[13] It is not unusual for the mass media to report terrible stories of gauze, scissors, nails and other pieces of metal left inside parts of people bodies undergoing operations; grave examples of neglect of a person by operating on a healthy organ rather than a sick one; underestimation of the clinical situation of a patient who is left to himself and then dies; of deaths caused by routine operations for appendicitis or angina; without speaking about episodes of corruption and situations of conflict which involve medical doctors and relatives of a patient in op position (to give only a few recent examples – cases such as those of Terry Schiavo or Eluana Englaro), etc. For a study of some such cases see PUCA A., *Etica della vita e della salute*, Camillianum, Roma 2004[2], pp. 129-177.

[14] Protests against the decisions of some regional authorities, including that of the Lazio region, forced to close healthcare structures in order to balance their books after going beyond their projected budgets, are by now a part of the national scene.

[15] COMMISSIONE EPISCOPALE PER IL SERVIZIO DELLA CARITÀ E LA SALUTE, *Predicate il Vangelo. La comunità cristiana e la pastorale della salute* (EDB, Bologna), n. 8, p. 11.

[16] Referring to the Prometheus-like approach of modern man, the authors of the above-mentioned Note observe: 'Two very evident symptoms of this conception are, albeit with differences as regards motivations and outcomes, on the one hand *exaggerated treatment* and on the other *euthanasia*. Seen closely, between exaggerated treatment and euthanasia there is a certain logical continuity because in them it is always man who does not accept addressing himself to death in a human way: with exaggerated treatment man uses all his means to postpone death whereas with euthanasia man arrogates to himself the right to bring forward and bring about death. In both cases, he wants to exercise an absolute dominion over life and death': n. 9, p. 12.

[17] The Servant of God JOHN PAUL II in his encyclical letter *Evangelium Vitae* writes as follows: 'The fact that legislation in many countries, perhaps even departing from basic principles of their Constitutions, has determined not to punish these practices against life, and even to make them altogether legal, is both a disturbing symptom and a significant cause of grave moral decline. Choices once unanimously considered criminal and rejected by the common moral sense are gradually becoming socially acceptable. Even certain sectors of the medical profession, which by its calling is directed to the defence and care of human life, are increasingly willing to carry out these acts against the person. In this way the very nature of the medical profession is distorted and contradicted, and the dignity of those who practise it is degraded' JOHN PAUL II, encyclical letter *Evangelium Vitae*, n. 4 (25 March 1995).

[18] CONFERENZA EPISCOPALE ITALIANA (C.E.I.), *Comunicare il Vangelo in un mondo che cambia* (Rome, 2001), n. 2.

[19] FIORENZO ANGELINI, 'Primo approccio agli ospedali cattolici oggi', in *Dolentium Hominum*, 52 (2003/1), p. 11.

[20] MARCHESI P., 'Umanizziamo l'ospedale', in MARCHESI P. L., SPINSANTI S., SPINELLI A., *Per un ospedale più umano* (Ed. Paoline, Cinisello Balsamo (MI), 1985), p.20.

[21] 'During the first moment I did not realise what was happening and to such an extent that I asked myself: am I so seriously ill that they are prohibiting me from receiving visits, telephone calls etc.! They told me that I sweated a great deal; this is true because once I was discharged I found a large number of pyjamas: so many changes, so many tests and so many medical examinations, now this, now that, and then having to 'obey' because the situation was grave. I moved my body without having any strength, without wanting anything, it was no longer my body, it needed everything, it belonged to other people, to medical doctors, to nurses…': REDRADO, J. L., 'Testimoni dell'amore nel dolore', in *Dolentium Hominum*, 63 (2006/3), p. 51.

[22] PETRINI M., 'Tradizione cristiana. Prospettiva cattolica', in PANGRAZI A. (ed.), *Salute, Malattia e morte nelle grandi religioni* (Ed. Camilliane, Turin, 2002), p. 38. Annota il noto biblista R. Fabris: 'The gospel tradition of which Mark depends… selected certain miracles of healing or liberation from physical malady and re-read them from a religous point of view. Thus, beyond physical healing, the gospel reading perceived salvation tout court, introducing into it a typicaally religious element – faith' (cf 7:1-10; 8:50)': FABRIS R., 'La salvezza secondo Luca', in BARBAGLIO G., FABRIS R., MAGGIONI B., *I Vangeli* (Cittadella Editrice, Assisi 2004[10]), p. 1221.

[23] GIOVANNI PAOLO II, 'La medicina è a servizi dell'uomo, di tutto l'uomo, di ogni uomo', in *Dolentium Hominum,* 7 (1988/1) 6, cf ID., *Dolentium Hominum* (Motu Proprio), n. 2.

[24] MARCHESI P., 'Umanizziamo l'ospedale', in *loc. cit*. pp. 27-28.

[25] MINO J.-C., FRATTINI M.-O, FOURNIER E., 'Pour une médecine de l'incurable', *Études*, 4086 (2008), 754-757.

[26] SPINSANTI S., *Umanizzare la malattia e la morte. Documenti pastorali dei vescovi francesi e tedeschi* (Ed. Paoline, Rome, 1982), p. 26.

[27] BUBER M., *L'eclissi di Dìo* (Mondadori, Milan, 1990), pp. 22.23, quoted in CHENU B., *Dio e l'uomo sofferente* (Edizioni Qiqajon-Comunità di Bose, Magnano, 2005), pp. 19-20.

The Mental Capacity Act 2005: Bioethical Assessments

In April 2005 the British parliament passed the Mental Capacity Act 2005 (MCA). From a bioethical point of view it is interesting to examine certain key points of it and above all to discuss the question of the artificial administration of food and water. According to some of the reactions to it, this law allows, indeed imposes on, medical doctors the obligation to withhold hydration and nutrition or to withdraw their administration of such things in the case of sick people who no longer have the capacity to understand or to decide and who had previously decided that these should be rejected. I will begin with a little history but I will then dwell upon certain key points and discuss, at the end, the question of artificial hydration.

A Little History

When a few years ago the first draft of this parliamentary document was published there were very many well-grounded concerns both on the part of jurists and amongst medical doctors. The jurists feared that one could procure a person's death by refusing to provide a life-supporting treatment. Doctors feared that they would be forced to cause the death of individuals because of negligence. Groups representing vulnerable people feared that this new law could legalise euthanasia. Out of respect for the common good many people and also Catholic bishops in England and Wales took an active part in the debate. At least one thing was clear: the law would not have changed the prohibition on euthanasia and on assisted suicide. In addition, nobody would have been able to take a decision as regards themselves or another person that sought to meet a wish for death. However, as regards the 'pro-life' guarantee certain problems still remained to be dealt with. It is interesting, therefore, to see what has been legalised in the sphere of bioethics and in particular as regards life-support through the artificial administration of food and water.

Key Points of the MCA

The Mental Capacity Act seeks to clarify what a person can do beforehand as regards a future situation when he or she is not able to understand or take decisions. It is presumed that every adult has the right and therefore the capacity to make a decision until proved otherwise. He or she can also indicate one or more attorneys who will then take a decision as to what is the best thing to be done for the patient. In this way the law seeks to guarantee the right of an individual to decide on what health-care professionals and social workers can and cannot do in relation to that individual. It should be pointed out that as regards the important matter of a prior decision involving the rejection of treatment needed to support life this must be done in written form with witnesses, be valid, and be applicable. It is specified that as regards what is in the best interests of the patient, this can never have the motivation of wishing to bring about his or her death.

It is interesting to observe that as regards the rejection of medical treatment, some people are more worried about the danger of under-treatment and neglect or even a lack of hydration (starvation) for elderly patients. Others are more concerned about the danger of over-treatment and the power of modern medicine to make the process of dying uselessly burdensome. The MCA indicates that it is important to bear in mind both these concerns. In this context the MCA addresses the decision on the end of life. First of all it deals with concern about the rejection of life-supporting treatment. The key point lays down that every human is irreplaceable and thus each life should be cherished, one's own life, when life is hard and at its end as well. The life of a sick person or a dying person or a disabled person should be respected on a par with that of a healthy person. Now, one reason for concern in people about the rejection of life-supporting treatment is the fear that a sick person will be neglected and not receive the treatment that he or she needs. To summarise: there is fear about so-termed under-treatment. There is a second and more important treatment because even if such neglect is requested by the patient, this can be because in that person there is a lack of value bestowed on his or her own life. The MCA also raises the question of why a patient may be worried about the administration of life-supporting treatment. Being mortal as we are, we know that we are destined to die. To live well, we should embrace this valuable gift and accept the inevitability of death. It is important to recognise that life will finish and to prepare ourselves for death in the best way possible. When death draws near we must be able to accept this reality and not look for futile forms of treatment. Many people are worried that they will not be allowed to die but will be subjected to unwanted and unnecessary treatment. To sum up: people are worried about resort being made to exaggerated treatment. What is worse: absent treatment or excessive treatment? It is rightly pointed out that two elements must be borne in mind: that of cherishing life and that of accepting death. The first means that death should not be the purpose of acting or not acting. The second means that one should not flee from the inevitable and look for a possible treatment that will prolong life when this

is futile. The MCA explicitly declares that nothing has been changed as regards the prohibition on euthanasia or assisted suicide, even when this is requested by the person involved on compassionate grounds. Both remain grave criminal offences according to English law and are important for vulnerable and depressed people. This law changed nothing on this point and thus it remains clear for health-care professionals and social workers and for those in positions of power that it is never legal to give or fail to give treatment in order to make people die. However, the MCA allows a prior decision to be made as regards treatment bearing on life and here we are dealing what are commonly known as 'living wills'. Given that here we encounter bioethical questions, I will now specifically address myself to this subject.

Bioethical Questions and Living Wills

The Code of Practice recognises forms of treatment called basic or essential care which are required to keep a patient comfortable and which should rarely or never be rejected. If a patient can swallow and digest he or she should always be offered nutriment and water by mouth. Health-care professionals should continue to provide such treatment in the interest of a patient who can neither understand nor take decisions. The law requires these patients not to be neglected and they should not suffer needlessly because of hunger and dehydration. In the case of Leslie Burke, Lord Philips said: 'when a competent patient indicates a desire to be kept alive through artificial feeding and hydration, any medical doctor who deliberately leads to the end of the life of the patient by not continuing does not only not do his duty but is guilty of murder([2006] QB 273 page 302) . When one moves to the prior decision of a patient the MCA declares that the decision can never be motivated by a wish to die.[1] For that matter, if somebody clearly requests suicide, the question arises of his ability or otherwise to engage in a decision.[2] But, and here the analysis changes, assuming that the prior decision to reject treatment is valid and applicable to the situation, the MCA then adjudges that it is illegal to provide treatment. In these circumstances the medical doctor cannot impose the treatment, even if this treatment would save the life of the person involved. This is because, if the decision in favour of rejection is legal, because it is valid and applicable, the artificial administration of food and water is illegal, *even if this leads to the death of the patient*. However, whenever hydration is necessary to remove discomfort, then the Code of Practice allows fluids, which should be seen, however, as a part of the general obligation to keep a person comfortable but not in order to support the life of a person. This is certainly hard for a conscientious doctor who works for the best interests of his or her patients. Whatever the case, given that the decision that leads to death is not taken by the medical doctor, one could say, and it is said, that the health-care worker is not guilty of negligence and the problems that result from it. There are limits as regards the help given to people and above all else when someone rejects all help, and in this situation nothing can be done. I do not agree, specifically because this is a question of cooperation in wrongdoing.

Cooperation in Wrongdoing by Omission

My disagreement is based first of all on the law itself because in prohibiting a decision that involves death it adjudges it to be illegal. In addition, in requiring that a medical doctor be concerned with everything that is best for the patient, he or she cannot passively witness the death of his or her patient. Thus how can the legislature assert that a doctor who administers food and water commits a criminal offence because he or she engages in an illegal action? But someone could continue, given that for the MCA the act of 'artificial feeding and hydration' is a medical treatment and thus can be withheld or withdrawn, that a health-care worker must take into account the wishes and feelings of the patient. Whatever the case, allowed but not granted, even if one is dealing with an illegal medical act, the behaviour of the medical doctor is certainly immoral because the legislation is unjust. John Paul II declares: 'The passing of unjust laws often raises difficult problems of conscience for morally upright people with regard to the issue of cooperation, since they have the right not to be forced to take part in morally evil actions'.[3]

To illuminate these difficult problems, Catholic morality refers to general principles on cooperation in evil actions. Because of a grave duty of con science, Christians like all men of good will are called not to provide their formal cooperation to those practices which, even though allowed by civil legislation, are opposed to the Law of God.[4] Thus in order not to act in *an illegal* way, it is never licit to act in an *immoral* way. Now, the artificial administration of food and water, although it does not transgress civil law, above all if this involves the death of the patient, means cooperation *by omission* in the death of the patient. This is what John Paul II teaches in *Evangelium vitae*: 'For a correct moral judgment on euthanasia, in the first place a clear definition is required. Euthanasia in the strict sense is understood to be an action or

omission which of itself and by intention causes death, with the purpose of eliminating all suffering. "Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used"'.[5] In answering certain questions of the Bishops' Conference of the USA about artificial feeding and hydration, the CDF declared, first of all, that the artificial administration of food and water is morally obligatory, even in the case of patients in a permanent vegetative state (PVS). In this way suffering and death because of a lack of food and water (starvation) are prevented. The CDF also declared, and this is very important, even though competent medical doctors adjudge with moral certainty that the patient will never regain consciousness, that this administration must continue because the patient is 'always a person with fundamental dignity and this must receive ordinary and proportionate treatment, which includes, in principle, the administration of water and food, in an artificial way as well'.[6]

The answers of the CDF authoritatively confirm the Catholic approach to the artificial administration of food and water: this is not medical treatment but basic care which, at the level of principle, must be provided. In order to avoid all misunderstanding, I would like to quote a declaration of the *Catechism of the Catholic Church*: 'Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of 'overzealous' treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected'.[7] The difference as regards administration is completely clear and brings out the confusion that is present in the MCA. What is legal and also moral when one speaks about medical procedures is neither legal nor, certainly, moral when one speaks about basic or essential care!

The Divine Right to Conscientious Objection

In the MCA, at least explicitly, there is nothing on conscientious objection. The Code of Practice adds something, declaring that health-care professionals and social workers are not obliged to do something that is against their beliefs. However, they must not simply abandon patients or cause them suffering.[8]

However, it is stated with all clarity that 'to refuse to take part in committing an injustice is not only a moral duty but also a basic human right. If such were not the case, a human person would be forced to carry out an action that is intrinsically incompatible with his or her dignity 'To refuse to take part in committing an injustice is not only a moral duty; it is also a basic human right. Were this not so, the human person would be forced to perform an action intrinsically incompatible with human dignity, and in this way human freedom itself, the authentic meaning and purpose of which are found in its orientation to the true and the good, would be radically compromised. What is at stake therefore is an essential right which, precisely as such, should be acknowledged and protected by civil law'.[9] Pope Wojtyla draws the logical consequences and declares: 'In this sense, the opportunity to refuse to take part in the phases of consultation, preparation and execution of these acts against life should be guaranteed to physicians, health-care personnel, and directors of hospitals, clinics and convalescent facilities. Those who have recourse to conscientious objection must be protected not only from legal penalties but also from any negative effects on the legal, disciplinary, financial and professional plane'.[10] Awareness of the inviolable good of life and divine law which jealously defends that right precedes all positive human law. When this human law contradicts divine law, the conscience affirms its primary right and the primacy of divine law: 'We must obey God rather than men' (Acts 5:29).[11] An authoritative confirmation of this comes from Benedict XVI who declared that conscientious objection is also a right of pharmacists. He said this during his address to the International Federation of Catholic Pharmacists: 'conscientious objection, which is a right your profession must recognize, permitting you not to collaborate either directly or indirectly by supplying products for the purpose of decisions that are clearly immoral such as, for example, abortion or euthanasia… they have an educational role with patients to teach them the proper dosage of their medication and especially to acquaint them with the ethical implications of the use of certain drug'.[12] It is certainly the case that following one's own conscience in obedience to divine law is not always an easy path to take. It can involve sacrifices and difficulties, whose weight it would not be licit to deny. At times heroism is needed in order to remain faithful to such demands. However, it is necessary to proclaim clearly that the life of the authentic development of the human person passes by way of this constant faithfulness to conscience maintained in rectitude and truth.[13]

Conclusion

The contrast between the MCA and the Catholic approach as regards the artificial administration of food and water is *luce clarius*. For one it is

medical treatment that can be rejected beforehand and can be interrupted; for the other, it is basic care that remains obligatory until nature itself rejects it. Hence it is evident that what is legal is not for that reason also moral. Indeed, quite the contrary! In fact, specifically in the bioethical field the difference is essential because it makes the legislative obligation not to administer, which is imposed on a medical doctor, simply immoral. Thus the true conscience, certain and upright, is not obliged to oppose the law but should commit health-care workers to contest such a legislative obligation. 'We must obey God rather than men' (Acts 5:29).

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Notes

[1] Cf MCA 1,5 and 4, 5.
[2] Cf Code of Practice, 9.9.
[3] JOHN PAUL II, *Evangelium vitae*, n. 74.
[4] Cf *ibidem*.
[5] *EV*, n. 65.
[6] See 1 August 2007.
[7] *CCC*, n. 2278.
[8] Cf Code of Practice, 9.61- 63.
[9] *EV*, n. 74.
[10] *Ibidem*.
[11] Cf. *Carta degli Operatori sanitari. Pontificio consiglio della pastorale per gli operatori sanitari* (Vatican City, 1995), 143.
[12] Cf BENEDICT XVI, address of Monday 29 October 2007.
[13] Cf CDF, *Dichiaraziione sull'aborto procurato, 18 giugno 1974*, in AAS 66(1974) 744, n.24.

Prior Decisions Concerning Life: a Guide for Catholics

The Minister for Justice of Great Britain published in 2005[1] 'The Mental Capacity Act' accompanied by a Code of Practice to explain the details of its implementation and the legal responsibilities that are involved. The Bishops' Conference of England and Wales in 2008 published 'The Mental Capacity Act and Living Wills – A Practical Guide for Catholics'.[2] In the preface the Archbishop of Cardiff, Peter Smith, clearly observes that this edition was necessary after the perplexity that had been felt in various quarters (see pp. 5-8). This Guide presents the possibilities that the Mental Capacity Act offers to people concerned as regards future health and treatment (see pp. 13-20). It seeks above all to point out the possibility of deciding, in the case of mental incapacity, to delegate this decision to a third party as regards the rejection or interruption of artificial alimentation – hydration and/or nutrition (ANH) (see pp. 9-12). I will now examine with the greatest attention the guidelines on prior choices from the point of view of conscience.

Choices Concerning Future Health and Treatment

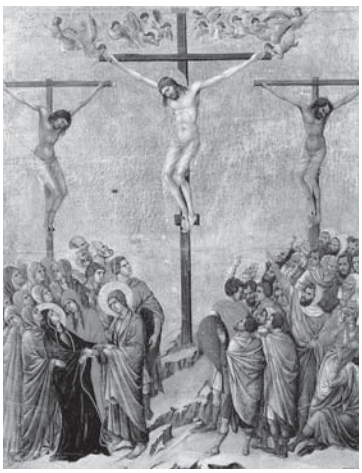
As regards the possibility of a prior decision, whether personal or delegated, with respect to medical treatment there do exist, on their own and in themselves, difficulties. We are dealing here with the right for it to be used with prudence, and patients can ask for treatment that is entirely appropriate to their wellbeing. It should be observed, however, that *not everything allowed by the Act is right from a moral point of view*. And it is made clear that the decision to refuse food and water is morally unacceptable (see p. 21, last lines). *If this treatment were refused with the intention of making the patient die, one would be dealing with a serious crime*. A medical doctor who refused artificial hydration and food, thereby causing the death of a patient, would not only not fulfil his deontological duty but would also be guilty of murder. The example is given of Leslie Burke, specifically with reference to ANH (see p. 22, at the end). It is further stated that the implementation of a prior decision can be changed.

The Moral Obligation to Accept Treatment

There is both a personal and a family obligation to engage in care for health.[3] However, there is no obligation to engage in useless forms of treatment, that is to say treatment that only prolongs life. However, two things must be borne in mind: love for life and acceptance of death. One can, therefore, admit under certain circumstances that the illness has its natural development, even though this means that one wants to die. As a confirmation of this the *Catechism of the Catholic Church* is quoted[4] (see p. 24 at the end and p. 25 at the beginning). At this point stress is laid upon the difference between the Catholic approach and the approach of the Mental Capacity Act. For this law ‚ANH is *medical treatment*; for Catholic morality it is a natural means by which to preserve life, it is a *treatment involving care*. The criterion is, and always remains, that of the greatest wellbeing of the patient. Thus a refusal or the interruption of ANH when the death of the patient is not imminent would be clearly against this criterion inasmuch as it would cause death. The case is different when the body itself engages in the rejection, in other words when it no longer absorbs or no longer excretes. In that case one is no longer dealing with accelerating death but of removing the disturbance of the tube. In addition, every decision to interrupt treatment must be done with upright in-

tention; this means, in a negative sense, that it must be never carried out with the intention of accelerating the death of the patient (see pp. 25-26).

As a confirmation of this, what John Paul II said about patients in a vegetative state is quoted: there is an obligation to provide the normal treatment of the use of nutrition or hydration. The Congregation for the Doctrine of the Faith (CDF) confirmed this obligation in its reply of 1 August 2007 to the question posed to it on the subject by the Bishops' Conference of the United States of America (see p. 27).



Questions for Health-Care Professionals and Social Care Professionals

The first professional implication is respect for the person being cared for and not causing him or her any harm. Professionals must identify the greatest wellbeing of the patient, show respect for human life, take care of the patient, and protect and promote his or her health.

Thus the decision to refuse a treatment with the intention of having the patient die, even if death is willed as a means, is never morally licit. Health-care professionals must never adjudge the life of a patient as not being worthy of life (see pp. 29-30).[5] So how should a health-care worker behave towards a patient when he or she is entrusted with a medical treatment of treatment involving care? The first step for good practice is to establish through dialogue the facts in the fullest way possible. Another step for good practice is correct ethics that avoid the danger of over-treatment or under-treatment. Whatever the case, it is important to encourage good practice as much as possible. But what should be done in the case of a prior decision that is no longer at the present time in the best interests of the wellbeing of the patient? This decision, however imprudent, remains legally valid. Let us suppose that a person took that decision many years ago when there was no suffering or illness. In this case there can be a reasonable doubt as to whether that decision is still *hic et nunc* applicable in the specific situation. For that matter, where the prior decision involves a rejection of treatment, even though this is now valid and applicable, the treatment is illegal. The law prohibits the medical doctor from imposing treatment even if this would save life. For a conscientious doctor who attends to achieving the best possible wellbeing of the patient, this is harsh. Obviously, he or she is not blameworthy as regards the consequences that derive from his or her non-provision of treatment because the law removes his or her professional responsibility in this area (see pp. 30-32).

What Should be Done if the Prior Decision is Suicidal?

The Mental Capacity Act establishes two things. The first is that every act that is carried out and every decision that is taken should aim to achieve the greatest wellbeing of the patient. The second is that a judgement in the matter cannot be motivated by a desire to bring about death. As a consequence, it is explicitly established that there is no legal change as regards a 'no' to assisted suicide or euthanasia. Given, however, that the suicidal motivation is not always evident to other people, a health-care worker must give the patient the benefit of the doubt and not presume that the refusal reflects a suicidal intention. It should also be observed that if the motivation is clearly suicidal, a question may arise as to the mental capacity of the person in question. Whatever the case, in rare cases of a suicidal refusal we must consider two levels: the refusal as such and cooperation with this refusal. As regards the suicidal refusal in itself, even if legalised, this is always self-destruction and non-acceptance of life as a gift from God. It is thus always something that should not be done.[6] With respect to cooperation, the Church teaches that 'voluntary cooperation in suicide is contrary to natural law'[7] (see pp. 32-33).

The Question of Respect in the Case of Refusal of ANH

The decision should be respected even if the refusal causes death. The Code of Practice says, nonetheless, that one cannot refuse beforehand actions that are needed to keep a person in a comfortable state. Liquids should be given if they necessary in order to alleviate a person's stress. On the other hand, the Code of Practice sees nutrition and hydration explicitly as medical treatment that can be refused. The bishops rightly make clear, and this is, and I repeat the point, the essential difference, that artificial nutrition and hydration should not be placed in the same category as medical treatment. ANH belongs to basic care and this, at the level of principle, should always be provided.[8] Even of the intention behind the refusal is not suicidal, the non-application of ANH has this effect. In this situation, health-care workers must do everything possible for the greatest wellbeing of the patient and consider whether the prior refusal is specific, valid and applicable or otherwise. In the case of doubt, they must provide ANH to the patient as long as they are responsible for his or her greatest wellbeing. In the case of dispute they must appeal to the Court of protection. Where the interruption of ANH is contrary to the greatest wellbeing of the patient, they must withhold their treatment of his or her (pp. 34-35).

Questions Regarding the Decisions of 'Third Parties'

The Guide goes on to make specific observations on matters that concern those who have to decide in the place of a person who is incapable of understanding and deciding. It is preferable that one is dealing here with a person who is referred to and whose name and surname are written down. For this reason, according to the law, it is not valid to indicate the position of a person, for example the Superior of a religious Congregation. As regards motivation, it is laid down that the decision can never be motivated by the wish to have someone die. However, the decisions have to be taken seriously. Let us suppose, however, that a medical doctor does not agree with the decision as regards the intentions. In that case the first step is a discussion in order to reach an agreement. If he or she does not manage to achieve this, an appeal can be made to the Office of the Public Guardian to intervene. Where the intentions are legal but where the medical doctor believes that the pathway of actions does not correspond to what is in the best interests of the patient, in that case the health-care worker can appeal to the Court of Protection. In the meantime the medical doctor can legally apply the treatment that he or she adjudges to be the best for his or her patient (pp.36, 5.8; see also pp. 43-46).

Conscientious Objection

The Mental Capacity Act of 2005 does not contain an explicit section on conscientious objection. Nonetheless, the Code of Practice lays down two points: the first is that health-care and social professionals are not obliged to do something against their own beliefs; the second is that health-care and social professionals must not simply abandon their patient. A medical doctor who adjudges a plan of action, for example, as regards the refusal of ANH, to be unethical, must speak and listen to his colleagues and to the relatives of the patient. Continuing to be certain that this plan of action does not serve the best wellbeing of the patient, the medical doctor must not formally cooperate, that is to say he or she must cease care for the patient. In the case of material cooperation, the medical doctor must, in the light of his or her ethical obligation, prudently weigh the alternatives (pp. 37-38). Aware of the complexity of material cooperation in a specific situation, the bishops do not give general rules but instead refer to the doctrine of the Church in this sphere. A great deal of practical wisdom is required which takes into account the factors that are involved in order to arrive at a judgement of conscience. Are there alternatives? How urgent is the action? What good or evil is possible? What are the possibilities of deception and scandal? What are the precise circumstances of the situation? Is this action in conformity with the special role, the responsibilities and the vocation of the individual (see appendix pp. 47-49). For further information as regards the teaching of the Church certain authoritative sources such as the *CCC*, the CDF on ANH (1 August 2007), the Charter of the Pontifical Council for Health Care Workers, and *Evangelium vitae* (1995) of John Paul II (see, pp. 40-41) are indicated. A glossary of the terms that are employed makes this Guide even more valuable (pp. 51-55).

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Notes

[1] See *http://www.justice.gov.Uk/guidance/mca-code-of-practice.htm*

[2] The Catholics Bishops' Conference of England & Wales, Department for Christian Responsibility & Citizenship, *The Mental Capacity Act and 'Living Wills': a Practical Guide for Catholics* (Published 2008 by the Incorporated Catholic Truth Society, 40-46 Harleyford Road, Vauxhall, London SE115AY).

[3] The *CCC* teaches: 'Life and physical health are precious gifts entrusted to us by God. We must take reasonable care of them, taking into account the needs of others and the common good' (n. 2288).

[4] 'Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of 'over-zealous' treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected' (n. 2278).

[5]. 'Best interests relate to the benefits and burdens of treatment should never reflect a judgement that the patient's life is not worth living' (p. 30 at the end of 5.2)

[6] The *CCC* teaches: 'Everyone is responsible for his life before God who has given it to him. It is God who remains the sovereign Master of life. We are obliged to accept life gratefully and preserve it for his honour, and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of' (n. 2280).

[7] See *CCC*, . 2282.

[8] The *CCC* teaches: 'Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted' (n. 2279).

Accompanying the Family

The biography of every patient is also the biography of his or her family: his or her attitudes, thoughts, memories, experiences and projects are inevitably bound up with his or her near or distant family relatives.

The family one comes from has a determining impact on the structure of one's identity and in the development of one's habits and tendencies which have a positive or negative effect on one's life.

A genetic map is not only an inheritance of physical and psychological features. It is also an inheritance of learning or limits as regards communication, the way in which one manages one's wounds or family secrets, lives out conflicts or differences, approaches difficulties or failures, and demonstrates affection or disapproval.

The family can educate a person to love, to engage in dialogue, to open himself or herself, to bear things, to give himself or herself, to forgive, but also to have prejudices, to criticise, to shout, to blaspheme and to hate.

Each family has its history and its dynamics. There are those who are born in family groups where they feel welcomed, affirmed and stimulated and those who are born in situations that are characterised by oral and physical violence, by fractures in relationships, and by a lack of ethics and of discipline.

However, it is important to bear in mind that we are the children and not the slaves of our past. Those who have been conditioned by their past in a negative way are able to overcome it by engaging in constructive choices and a process of interior maturation. A difficult past does not make us unhappy for ever.

The Impact of a Grave Illness on a Family

An unfavourable diagnosis, which threatens the life of a loved one, produces strong structural and relational changes in a family. Faced with a crisis that removes tranquillity, threatens internal equilibriums and forces people to adopt new roles and tasks, the various components of a family can react with anxiety-inducing, aggressive, balanced, blame-attributing, constructive or depressive attitudes and so forth.

Each family adopts different strategies in responding to illness. Amongst the commonest attitudes or mechanisms are *denial* – the rejection, the non-acceptance of the illness, the idea of behaving as though nothing had really happened; *hyper-protection* – on the one hand concealing one's feelings from the patient and on the other the practice of a conspiracy of silence, the truth of the situation is not openly communicated; *idealisation* – one may observe an excessive trust in the 'omnipotence' of medical doctors or in the miraculous power of medical science or forms of treatment; *sublimation* – an attempt is made to find refuge or consolation in spiritual certainties: 'pray if you want to get better'; 'those who believe do not cry'; *dramatisation* – there are disproportionate and hysterical reactions; *acceptance* – there prevails an attitude of healthy realism and balance and positive cooperation with the health-care workers; and *regression* – there is closure and social isolation in the face of a drama which the person thinks other people cannot understand.

In general, the response of a family to the event of illness involves *disorganisation* and dismay. There then follows a moment of *research*: the members of the family ask themselves about how they should face up to the situation by activating the resources of the group. A third stage involves the gradual adaptation of the family group to the changes that have been imposed on it by the illness.

Whether the crisis is managed positively or negatively depends on the kind of family system that exists, on whether it is fundamentally healthy or problematic.

Healthy or Problematic Families

Virginia Satir, a famous scholar who studies family problems, has drawn up certain criteria which allow us to discern whether a family tissue is fundamentally healthy and able to face up to critical moments or whether it is problematic and helps to complicate the impact of suffering and death. *Healthy families* are characterised by: the emotional balance of their members; respect for and appreciation of the individuality and diversity of every one of their members; a positive relationship with society; a high level of cohesiveness and communication amongst their members; a general stability of the family structure based upon clear norms and rules; a flexibility and not rigidity of the roles within it. *Problematic families* are characterised by: attitudes involving control and authoritarianism on the part of one of their members in relation to the other members; a tendency to destructive criticism; an absence of important individuals and models (for example of a parent because of death or divorce); a lack of affection where the relationships are based upon emotional distance; an internal disorganisation evident in roles and lifestyle; and the presence of specific problems such as mental illness, alcoholism, sexual abuse, drug addiction.

It is clear that whether one is dealing with a substantially 'healthy' or 'sick' family has a profound effect on reactions to, and the living out of, the event of illness.

In other words, as regards

the attitudes that are adopted one does not begin from zero but with the baggage of one's past, with the climate created by one's parents and the way in which they related to each other and their children.

Fundamental Tasks

Those who create a family take on two fundamental tasks:

1. *Educating in love and intimacy*

Parents are called first and foremost to bring up their children to develop ties, to feel loved and to love. This experience helps them to feel accepted and appreciated and to start off well in life. On the other hand, where affection and warmth do not exist a child experiences insecurity, loneliness and at times a sense of being abandoned. In general this first task is interpreted by the mother who welcomes, nourishes and supports the lives of her children. There is the risk that excessive love will be transformed into possessiveness or jealously and will interfere with the healthy development and independence of her children.

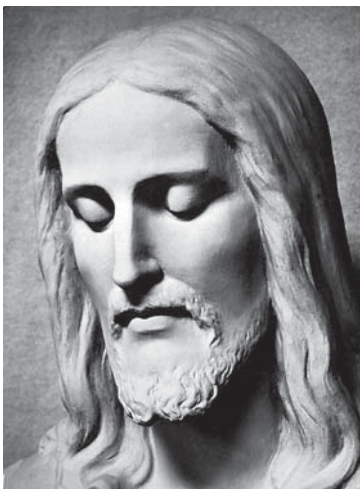
2. *Educating in separation and respect for differences*

A child is not a copy of his or her parents but instead is called to realise his or her own individuality and difference. A healthy process of growth helps him or her to establish limits, to define the boundaries between himself or herself and his or her neighbour so that he or she does not fuse with, or become absorbed by, other people. The pedagogic of separation is an invitation to bring out one's own uniqueness. One way of educating in separation is through the development of expressed or tacit rules which the parents transmit to their children. These rules concern various spheres of life: from how to manage emotions to how to express intimacy, from rules about work to rules about behaviour, from rules about safety to rules about relationships with other people, and from rules about sex to rules about facing up to pain, illness and death. Some of these rules are very useful and are internalised by children for the whole of their lives; others can generate major difficulties and block growth. The task of educating in separation is often the work of the father.

These two tasks, which are so essential in facing up to life with openness, realism and dynamism, are of extreme importance during the final stages of our pilgrimage on earth as well.

The experience of dying allows a patient and his or her family relatives to experience, first of all, valuable moments of intimacy, giving expression to feelings of mutual gratitude and communicating them through gestures and non-spoken language.

At the same time, the approach of death requires the courage to prepare oneself to say goodbye, to prefigure the detachment by assuring the continuity of the tie through memories, the horizon of the transcendent, and spiritual nearness.



Health-Care Workers and the Family

The crisis of illness opens up the doors of a hospital not only to the patient but also to his or her family. The family is not a spectator but a direct protagonist in a drama that concerns it. In the accompanying of the patient it is in the front line on a long and difficult journey that goes from the initial stage of diagnosis to the acute stage of therapy, from the stage of remission and hope to the stage of relapse when everything becomes complicated, and on to the final outcome when the therapies are palliative and preparations are made for detachment.

The family often becomes responsible for the most demanding part of care, especially in the domestic context.

Despite all this, especially in health-care institutions, the family is often systematically neglected by health-care workers who, instead, devote all their attention to the sick person. Some observations are thus necessary: the observation that the family is often kept at the margins or ignored by the health-care staff; one often notices attrition or competition between the health-care workers and the family as regards responsibilities in caring for the patient; the family is seen, at times rightly, as a burden or an obstacle in the process of care and treatment; the information that is transmitted as regards the condition of the relative or the purpose of the therapies that are used is formulated in a hurried way and in a technical language that is not very understandable; and at times there is a tendency to exclude the family from decisions that in some ways concern it.

The burdens of a grave or terminal illness invoke dialogue and concrete cooperation between the health-care workers and the family.

In particular, the unity of the family should be safeguarded as an essential objective or care and treatment.

Challenges for a Better Accompanying of the Family

Within institutions many families trust and entrust themselves to specialists and technology in order to obtain the best results at the level of care and treatment for their relative. At times, they may feel disturbed by a lack of attention and communication, by the limits imposed by the rules,

and by functional relationships that are inevitably depersonalising.

But it is above all within the domestic walls that the family has to manage the long trial of illness. Many of its members feel oppressed by the excessive responsibility, without medical or nursing support, and worried about the increasing problems that taking care of a seriously ill person involves.

The tasks of care which are increasingly burdensome physically and psychologically consume the family relatives and run the risk of producing depression and hopelessness.

Society, through its health-care resources, voluntary work and religious institutions, is called upon to be near to these families in order to make their *via crucis* less painful and make them feel less out on their own.

Some general guidelines for support include: activating palliative care teams made up of medical doctors, nurses, volunteers and other professionals in order to respond in a more effective way to the various needs of the patient and his or her family relatives; creating a climate of cooperation between health-care workers and families and open communication which fosters information and provides space for listening and questions so as to help the patient in a more effective way; fostering a unitary approach which contemplates not only the needs of the sick person but also those of the family unit; paying attention not only to physical needs but also to psychological and spiritual ones in order to assure an overall service; monitoring the changes that are taking place within the family at the level of relationships, changes in roles, the restructuring of habits, levels of tiredness, the use of resources, signs of anxiety or depression…; teaching the family relatives the techniques of caring and of physical and psychological assistance in order to promote better care for their relative; and accompanying the family relatives not only during the stages of anticipatory mourning but also during those that follow mourning and adaptation to a modified life.

Inasmuch as the family receives psychological support and practical information on how to help and comfort a relative, the event of dying – albeit painful – .will not produce bitterness and dismay but will be experienced in line with human nearness and solidarity.

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Testimonies

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Physician and Apostle: a Survey of the Life and Virtues of the Servant of God Pedro Herrero Rubio

Pedro Herrero Rubio was born in Alicante (Spain) on 29 April 1904 to a well-off family and was the only child of Pedro and Emilia. His father received a monthly salary from the Provincial Government of Alicante and was later mayor of the municipality of Orihuela. Pedro did not fail to have the resources of a human upbringing, both as a baby and a child, and this situation continued until his specialist university education at prestigious centres in Spain, France and Belgium. He married on 29 April 1931, at the Sanctuary of Our Lady of Monserrate di Orihuela. His bride was Patrocinio Javaloy Lizón who was also member of a prosperous family. Both had had an attentive Christian upbringing.

The Development of his Life. Testimony

Dr. Carlos Mazón, a hospital doctor: 'Father Herrero was the father of paediatrics in Alicante; he enjoyed speaking about his own city, spontaneously remembering in his conversations typical personalities he had known during his childhood, elements of history, traditions and his numerous friends'. 'As a person I can say that he did not seem to belong to this world.. He always lived in a far off way, a distract way… a militant Christian, with a rooted faith, whose witness was a living and constant example which we would all like to emulate. As a professional doctor one could define him in the following terms: he gave of himself completely. For him, working hours did not exist and he dedicated himself to his patients with the best of his expertise and the broadest of smiles… He could have died a millionaire but he died in the shade of the patrimony of his wife, thanks to whom he was able to engage in innumerable works of charity'

A Professional Doctor

Dr. Rivera, ex-president of the College of Doctors of his Province described him as 'an exceptional doctor, the prototype of an altruistic vocation, an exemplary companion and deep friend, but above all an eminently good man'. 'Pedro was happy in being able to help others to look for happiness and he found no better pathway than that of dedicating himself completely to doing good… He chose the medical profession because he perceived that amongst the best ways of doing good in the world he lived was that of being a medical doctor. In addition, he chose paediatrics (of which he was a pioneer and mentor in our Province) because he knew that children have the greatest need of protection, above all when they are sick, especially in the society of his time which was so populated with invalids… Medicine was not an end for him but a means, a means by which to do good'.

A Prestigious Doctor

We may observe in passing various national and provincial honours such as the Gold Medal, or local honours such as the Distinguished Son of Alicante Medal, but we cannot but remember what he said to Dr. Matilde Jover when, at the height of the *Rambla de Méndez Núñez*, she congratulated him on the award of the charity cross first class with a white ribbon (August 1978): "Matilde, my glory is the cross of Our Lord Jesus Christ". This answer remained for ever inscribed in the heart of that prestigious paediatrician.

Asín Lamaigneire**:** 'He was up-to-date with the latest medical knowledge because he studied in order to continue and update his medical criteria'.

Faced with illnesses that were strange at those latitudes, such as infantile Kala Azar (a desert malady), which two young daughters of a poor family, whose father was in prison because of the war and whose mother was in a state of total poverty, had contracted, and frustrated at his fruitless attempts to find a cure for the illness, he went to Paris and Brussels to study the case, engaged in research and returned with the right treatment. He paid for everything out of his own money – his trips, stays and the drugs. He had the girls admitted to the Charity Hospital together with their elder sister aged nine; he subjected her to a rigorous supervision because to get better she had to eat only tomatoes and honey. She was protected day and night by a kind of crystal sphere. From what the girl, who is now an adult, says, Don Pedro entered that little dwelling for nine days and on his knees said a number of prayer. It must have been the novena of Our Lady of Remedy, the patron saint of Alicante.

In this way of doing things the Servant of God Pedro Herrero Rubio presented himself to God at the end of his existence in this world. Those who knew him could not find a better epitaph for his grave than the following: 'Pedro Herrero, physician and apostle'.

Apostle and Physician

When as a child he played at celebrating Holy Mass with his friends in the street and gave childlike sermons, the desire to make others better seemed to spring from his limpid conscience which was taking its first steps forward.

For this reason, some of the witness as his process stated that when Dr. Herrero entered the home of a sick person one did not know whether the man who came in was a physician or a priest.

Nobody left his company without being spoken to about God, without being invited to wed the Church, or without stress being laid on the fact that the child should be baptised or that a person should pray. Indeed, he himself asked for a certificate of baptism, marriage or death in order to facilitate the bureaucratic process that was required in each case. After his death many of these documents were found in his office as well as letters received from bishops, parish priests and mayors about cases where he had been an intermediary in order to help his increasingly poor patients.

Because of the religious persecution of 1936 he said to one person who spoke to him: "For me everybody is equal, all people are children of God and if we should exaggerate in our care it is precisely in relation to those who say that they are distant from God".

He was an active member of Catholic Action. When the second anniversary of the pontificate of Pius XII was celebrated it was he who gave the principal speech in front of the four branches of Catholic Action.

José Mª Simón, a lawyer: 'He dedicated all his energies to Catholic Action above all as president of the diocesan council of the men's branch… he gave of himself totally in all his works and to such an extent that he left behind him as he passed by an impress that cannot be cancelled'.

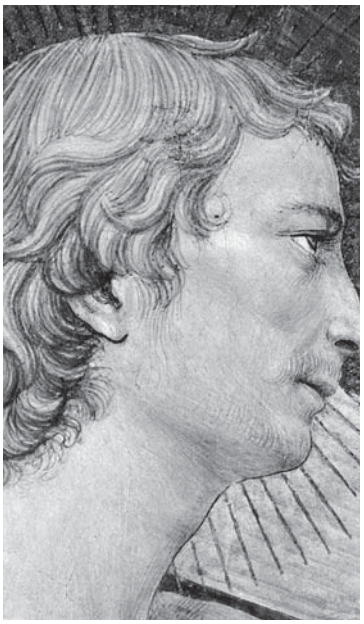
A Doctor of Prestige who United Science and Faith

Because during the period of the civil war and in the immediate post-war years spiritual needs were at time extremely high, Don Pedro took advantage of his ministry with children to baptise his little patients or to invite people to regularise their matrimonial situations.

Monsignor Barrachina Estevan: 'His zeal for the wellbeing of souls was demonstrated, for example, in asking for documents from parishes for his children, at times to obtain the marriage of their parents and at times to baptise a family relative'.

'One day he had a couple of gypsies marry in church. However, at the end they withdrew because they thought that their clothes were not suitable for the occasion. Don Pedro then sent them to his home so that his wife could give his wedding clothes to the groom and dress the bride, and thus it was that the wedding could be celebrated'(Hermana Guadalupe).

His wife, Donna Patrocinio, declared: 'He was primarily concerned about the spiritual salvation of everyone, he prayed for his patients; at times people said that he worked miracles'.



Dr. Rivera: 'He practised the specialisation of paediatrics out of a vocation, inasmuch as he believed that a child is a being in need of protection, and even more so if that child is sick… The whole of his life was an apostleship because for everyone that came into contact with him, the friends and family relatives of his patients, he was an example of Christian virtue, in that his example was very great'.

A Profoundly Religious Man

This Servant of God lived his Christian life in a constant spiritual growth that lasted for the whole of his life. The foundation of his faith was a personal relationship that was close and continuous with the Risen Jesus Christ. He was very devoted to the Passion of Christ, the Sacred Heart of Jesus and the Most Holy Face of Christ.

His devotion to the Eucharist and Mary was typical of a well formed man, a strong devotion which every day was more fervent. As a night worshipper, he was a model.

Hª Guadalupe: 'When he was told to rest during his nights of nocturnal worship, he replied "There is a great deal to repair. There is a great deal to ask from God for sinners"'.

Always Ready to Help Anybody

At the height of the war and the religious persecution in Spain, three armed militiamen knocked at his door in the middle of the night and said to him "come with us". Don Pedro took his clothes (without doubt he relied upon his wife in this area until reaching eternity) and went out with them. While they were walking along they told him that one of their daughters was seriously ill and that they were taking him to treat her. The girl recovered from her illness. The father of the girl wanted to pay him for this by offering to kill anyone who molested him on his way back to the president's office of the College of Doctors. Don Pedro, who never allowed himself to be paid, no less did not accept the payment that the militiaman offered him.

His wife: 'His colleagues and nurses said wonderful things about him and they did not protest or feel fear, but they knew that he required good treatment for sick children, especially those that were poor'.

The titular bishop of that period has stated: 'When he visited the poorest children he displayed great respect, he required the greatest care towards them because he always loved them very deeply… A virtuous life dedicated to other people, above all to the poorest and invalids who for him were the children he treated and amongst these the orphans of the provincial charitable association'.

A. Mancebo: 'During the Spanish Civil war (1936-39),

the Servant of God was imprisoned together with a group from Alicante on the prison-boat 'Rita Sister' which was anchored in the port of Valanza. He was freed from this thanks to the intervention of the workers and militiamen of the port of Alicante who pointed out that he was a doctor who treated their children for nothing. On the other hand none of the adults in the houses next to his returned from the front. Don Pedro returned safe and sound, he was never molested and he was protected by the workers and militiamen

Don Amalio, his assistant health-care technician: 'I remember that he even treated for nothing the sons of a man whom he could not bear because he was a very ardent Communist'.

Don Francisco Llaneras: 'He was taken to the front at Teruel (December 1938-January 1939) to serve the Red Army as a soldier in the village of Alobras and in that locality he treated for free the sick people of the village who asked for his help'.

During the years 1939-1966 our medical doctor matured in a professional sense. The *Auxilio Social* was the body that sought to remedy the living conditions that afflicted the less favoured classes of Spanish society in the post-war period. This was an opportunity for Don Pedro to test out his great heart and he attended to the children of the foundations of the Gota de Leche in the famous Paseíto de Ramiro, in the medical dispensary of the sea port called 'Madre e Hijo', and above all in the 'Hospitalillo' of the provincial charitable association.

Even though he was very devoted to the Eucharist, in order to care for his neighbour he left everything to serve him or her. Witnesses have declared that at least twice, as far as they knew, even though he was already wearing evening dress and had in his hand the staff for the Corpus Domini procession, when asked by a mother or a father who were worried about their children and wanted his help, he left his staff behind and went to visit those sick children.

Ora et Labora

This Servant of God had absolute trust in the Lord but did everything possible to learn about medical science and to use it for each one of his patients.

From the homily at his funeral: 'Full of God, as one who had received Mass and communion, he threw himself into our streets, squares and nearby and distant villages, and imparted his medical science with the vocation of a priest and the dedication of an apostle'.

A Man of Prayer and of Worship

Msgr. Barrachina, bishop emeritus: 'Don Pedro was rigorous as regards everything connected with God, the Most Holy Trinity and the Most Holy Virgin, and the Eucharistic presence of Christ. The sacristan of San Nicola told me that during a wedding the groom fainted. Don Pedro hurried to help him but while attending to him heard the bell that announced the consecration and immediately left the sick man and set to worshipping the Most Holy Host'.

Dr. Javaloy, grandson of the Servant of God: 'At the end of his prolonged and at times tiring mornings of work, although we were tired and hungry and it was already 3.30 or 4.00 in the afternoon, and we had not had a mouthful of food since 9.00 in the morning, before going home he always took me to engage in a moment of prayer before the Most Holy Host in a monastery near home' (Capuchins).

This Servant of God studied every case in detail; he engaged in research and prayed for his patients.

Donna Pila Artiaga: 'I am a witness to the rigour with which he studied the cases of his patients because for the whole of my life I saw the light of his home turned on at half past five in the morning and I observed that he did this in order to study, and he did this every day until the hour of Mass'.

His wife donna Patrocinio has declared the same and added that he studied every case in detail.

Don Salvador de Lacy, a lawyer: 'For him the lunch hour was imprecise and very many times the goodness of the meal diminished because he came to lunch late. He took a very brief nap in a chair and then went to his personal clinic which was in his home and which opened without exception at five o'-clock in the afternoon… He did not fail to take advantage of every opportunity to advise and instruct in a doctrinal sense both parents and family relatives'.

The engine that moved his great heart to dedicate itself to the performance of so much good was his profound faith which was expressed in love for the Most Holy Eucharist: every day he began his working day, which went from 5.30 in the morning until 11.00 or 12.00 at night and at times until 1.00 of the following day, with Holy Mass which he always attended with his wife.

The first Friday of every month he made his care available in his parish in order to

take communion to the sick and he did this with a devotion narrated by the priest. Don Federico Sala: 'I am a witness to this, and it did not only happen once. When on the first Friday of the month he took the Most Holy Host with his car to comfort a number of patients and when the car drew near to Piazza St. Nicholas, he or his wife began the rosary until the neighbourhood of Requena where a sick woman lived. If because of heavy traffic the journey lasted longer than expected, he added a number times the stations of the Most Holy Host to the rosary. During the journey he never pronounced a wasteful word… If the sick person was poor, without allowing that person to realise it he left a sizeable sum of money under the pillow'.

'His nights of adoration were an example for his companions: he worked with enthusiasm to conserve and spread the worship of the Eucharist. For ten years he was emeritus vice-president, as is written in the minute book: 'a title that is granted to the Distinguished Mr. Don Pedro Herrero Rubio, in recognition of his extraordinary merits as constant and veteran adorer of the Host and man of good'.

Generous with the Poor

Dr. Don José Riquelme. 'We lived with Pedro in the university lecture rooms. At that time he already bore clear witness to his profound and constant religious direction and propensity to charity. Once, when he was student in Madrid, he saw a man pass by in Lavapiés Square; his countenance was that of a suffering old man and he was wearing summer clothes in the month of January. The cold made him tremble and he had a pale and afflicted face… he invited him to come to the home of his uncle and aunt, near to the square where he lived, he gave him one of his most comfortable overcoats and treated him affably'.

Mrs Asunción Rubio states that because he belonged to the Conferences of St. Vincent de Paul and to the Caritas group of his parish, Don Pedro asked them to point out to him where the most needy poor were so that he could give them things and other forms of care. At times I said to him: "I don't want to say anything else to you because I know how you are. I do not tell you to give to me". And he answered: "Showing me the homes of poor people is a good thing because for me to give to the poor means to have a piggy bank that is in heaven and means that the Lord looks after me. What we give is very little; it's a disgrace. If we do not know the cases, we do not sleep. You will be doing me a favour if you point out the homes that should be helped. To give to the poor means to give thanks'.

After his death many families testified that Don Pedro, after visiting a patient, left gifts under the pillow without anyone, not even the priest, realising the fact.

His wife: 'He cared for the sick until their end. He was wonderful. During the night, at whatever hour, he went quickly to find his patients'.

Mrs Martínez Sala. Donna Patro told me: 'You do not know what that man was: every morning when we left home to go to Mass, the first thing that he asked me was: "Patro did you remember it?" And he was talking about money for alms and this was to make sure that I was carrying it in my purse. All the poor people were waiting at the doors of the College of St. Nicholas to receive help from Don Pedro'.

Donna Adela Mancebo, second cousin of the Servant of God, has stated: 'His charity towards his neighbour was completely exaggerated. For example: Almansa is a town that is 92 kilometres from Alicante and every time that they called him to treat the sick even though it was dawn he went in a taxi to reach it (Almansa) and he paid the fare out of his own pocket. He asked if the family could pay the fare and if they told him that it could not, not only did he not make them pay but he even left some money under the pillow, and this is addition to paying the taxi fare'.

Ginés Ortuño, a driver from Sanidad: 'When he visited sick children in the poor neighbourhoods he left a hundred peseta note under the pillow after examining them. He did this to help them pay for the prescription. At that time a hundred pesetas was worth two day's pay'.

In Grottoes and Hovels

After the religious persecution of the 1940s and 1950s, this Servant of God also helped sick people in the grottoes of the neighbourhood of San Blas, of the Castle of St. Ferdinand, of the poor houses of Las Provincias (near to the Castle of St. Barbara) and the neighbourhood of Cortés (which was completely inhabited by gypsy families who lived as they could in shacks or grottoes).

Dr. Amalio Pérez, assistant health-care technician, has told us: 'He felt no repugnance sitting with complete amiability and affection next to patients with tuberculosis, typhus, meningitis and every other kind of illness which made their home in those people who had no hygiene or any kind of comfort; he sat next to them on their beds or a straw bed on the floor, full of poverty, lice and all that ilk; I was unable to do this, I felt repugnance at that state of affairs, but he did not. With what affection he treated them! I was unable to reach his level'.

All the sick people of those grottoes knew that charitable 'children's doctor', whose humble care, without fail, took them to clinics if this was the right course of action. 'Many times visits, lifts and gifts were the same thing', remembers Fr. Federico Sala.

Don Amalio (an assistant health-care technician) has declared: 'Don Predro went round the whole of the city, both in the most populated neighbourhoods and in the poor and disadvantaged outskirts. I knew all the districts and he, who trusted me, called me to help in all the services that he provided to his patients, rich and poor alike'. 'Some time when I was taking one of my children to his home he attended to us when he had finished with the rest and I saw

that he was very tired; I said to him: "You are very tired, please have a rest", and he replied "No, I am fine, furthermore I have to make some visits and he listed for us a series of sick people whom he had to see in specific places which at times were faraway. That looking for poor and sick people in those hovels in those barren fields which surrounded the city of Alicante; that going on stone roads at any moment, encountering at times rain and low temperatures during the night. He did everything for God. He wanted God to smile at him'.

Don Amalio goes on: 'Don Pedro, seeing that a gypsy mother did not know how to remove the sores of the spots of measles, spent a night in her grotto, charitably treating a baby so that it would not have marks on his face. It was not strange to see him wash a child in a grotto when its mother was ill'.

Sr. Guadalupe de las Heras, Daughter of Charity: 'Although I am a Daughter of Charity, it was Don Pedro who taught me what charity is. I learnt at his side what charity is. Whereas professionally he was an institution, his human values were extraordinary. The whole of Alicante knows this. I always called him Saint Pedro because a person as good as he was could not exist… If a child fell ill at three in the night and I did not call him at home… the next day he would rebuke me, even though I had doctors who could have done the thing perfectly. He was like that'.

Rev. Fernando Mata, OP, priest and doctor: 'He was very interested in founding a retreat in Alicante and he managed to do this; in response to his invitation I gave a series of talks in Alicante and directed a series of spiritual exercises for health-care workers organised by the Brotherhood of Saints Cosma and Damian, of which the Servant of God was president until his death'.

'I Have Seen Jesus Christ'

On one occasion a canon of St. Nicholas visited a sick man who was prostrate on his bed. After the first words the sick man said to the priest: "I have seen Jesus Christ". The priest replied: "Yes, when you have a high temperature you can have visions". "When I say that I have seen Jesus Christ", answered the sick man, rather seriously, "I am referring to a good man who without knowing me visited me, administered to me, treated me and even took me to hospital, that man is Don Pedro Herrero".

These brief descriptive elements show the pathway of a Christian who knew that a baptised person must be a saint and an apostle.

The death of Pedro Herrero produced a great feeling in those who had known him. Proof of this was the huge crowd at his funeral and *the unexpected decision of the bishop who was present, who announced the forthcoming opening of the process for his beatification. Laus Deo!*

H.E. Msgr. RAFAEL PALMERO RAMOS,
Bishop of Orihuela-Alicante, Spain

Spain: the Association of Christian Health-Care Workers

The Association of Christian Health-Care Workers is an association of the faithful with a public juridical status and was created by the Spanish Bishops' Conference.

The goals of the members of this association are: to promote the Christian laity, to create channels and contexts of encounter; to help health-care workers in the human, spiritual and bioethical field; to cooperate in the promotion of health; and to contribute to the defence of the rights of people in health or sickness.

Within the context of these goals, annual meetings are organised such as the one that was held 15-17 May in Avila and involved the presence of about a hundred health-care workers. They reflected on conscience, responsibility and solidarity in the health-care/social world, 'convinced', as Dr. José Maria Rubio, the President of the Association, said, 'that solidarity, ethics and spirituality are the challenges and principal goals of our profession, and together we can meet them'.

Msgr. Jesús García Burillo, the Bishop of Avila, presided over the inaugural ceremony of the meeting and afterwards bid those present welcome to the city where St. Teresa, a model sick person and patient, was born, and expressed the hope and wish that the participants would have the same feelings that had done and with which she overcame her illness: wisdom, patience and union with God. Rudesindo Delgado, the Ecclesiastical Assistant of the association, read the message of greetings and encouragement sent by H.E. Msgr. José Luis Redrado, Secretary of the Pontifical Council for Health-Care Workers.

Three exceptional speakers, Emilia Sánchez Chamorro, Francisco Alarcos and Juan Martín Velasco, helped us to learn about contemporary health-care/social realities, the right keys by which they can be addressed, and the resources by which within them a Christian life can be lived.

The participation in the three work seminars was active and enriching. These were held contemporaneously and were on conscientious objection at the beginning and end of life and in ordinary care.

We were able to count on the presence of H.E. Msgr. Rafael Palmero, the head of pastoral care in health, who presided over an excellent Eucharist at the Monastery of the Incarnation of the Carmelite sisters. He took part in the seminars on conscientious objection and offered some very illuminating words on the most urgent challenges facing the association: its renewal and internal and external energising, the need for constant ethical and moral reflection on its professional activity and the role of Christian witness in the world of health and life, with special care being given to the weakest and most in need.

At the prayer meeting, the writings of St. Teresa and St. John of the Cross allowed us to enter the roots of faith, the celestial joy and pathway of God. A letter of St. Paul and other texts taken from his writings were read. During this meeting humour and happiness were not absent and we called it '*tibilorio*'.

We were accompanied over this period by Dr. Alexander Sherchenko, the envoy of the Metropolitan of Voronezh and Borisoglensk, the President of the Synodal Department of the Church of Charity and Social Services of the Russian Orthodox Church and President of the Medical Doctors of the Orthodox Community of Russia.

Below we reproduce the greetings of the Bishop of Avila, H.E. Msgr. Jesús García Burillo, and of H.E. Msgr. Rafael Palmero, the bishop responsible for pastoral care in health within the Spanish Bishops' Conference.

Rev. RUDESINDO DELGADO
Ecclesiastical Assistant of the PROSAC (Association of Christian Health-Care Workers), Spain

Greetings of H.E. Msgr. Jesús García Burillo

'that the God of our Lord Jesus Christ, the Father of glory, may give you a spirit of wisdom and revelation' (Eph 1:17).

It is a great pleasure for me to welcome all the participants in this sixteenth National Day of Christian Health-Care Workers. Dear Mr. Rudesindo, Mr. President and members of the PROSAC association, Don Abilio, Director of the Department for Pastoral Care in Health of the Spanish Bishops' Conference, I would like you to feel at home. The city of Avila opens its doors to each one of you and to all your association. We are very happy to host an experience of the Church such as this one, in which you are about to take part.

In the Book of Wisdom we find Salomon's speech on the nature of wisdom and this ends with a prayer. I would like to make it mine at the beginning of these greetings, asking God for this gift for all of you: 'O God of my fathers and Lord of mercy, who hast made all things by thy word and by thy wisdom thou hast formed man, to have dominion over the creatures thou hast made, and rule the world in holiness and righteousness, and pronounce judgement in uprightness of soul, give me the wisdom that sits by thy throne… for even if one is perfect among the sons of men, yet without the wisdom that comes from thee he will be regarded as nothing…

Send her forth from the holy heavens, and from the throne of thy glory send her, that she may be with me and toil , and that I may learn what is pleasing to thee' (Wis 9:1-10).

When I was sent as a bishop to this city to take part in that ring that in the apostolic succession leads us back to the founder of the Church of Avil, St. Secundus, one of the seven 'apostolic men', I took up the words with which John Paul II began his visit to Spain in 1982: 'I have come to Avila to worship the Wisdom of God'. May this wisdom illuminate your deliberations of the sixteenth World Day of Catholic Health-Care Workers, in a land, that of Avila, which has given great saints to the Church in whom divine Wisdom left its tracks, above all in those who are luminous lighthouses in the Spanish Church and the Universal Church, St. Teresa of Jesus and St. John of God! I invite you to open your hearts to welcome, as they did, the Wisdom of God.

We are in the city that was the birthplace of St. Teresa. There are many people, every day, who come here from the five continents of the world to learn about this city and in particular to visit places where this saint was born, lived, prayed, reflected, founded a new Carmel, and was an extraordinary model as a woman, humility and life as prayer.

Teresa was also a model as a sick person. I am sure that all of you would have wanted to have had her as a patient. St. Teresa in her life suffered because of various illnesses. In the Convent of Grace here in Avila, which she joined when she was still a teenager, she remembered that she 'had a major illness which made me return to my parent's home' (V 3,3). Of her childhood she remembered that 'with my fever came great weakness. I have always had bad health'(V 3, 7). During her novitiate in the Convent of the Incarnation, at the age of twenty, she overcame 'the terrible illnesses that I had, with the great patience that the Lord gave me' (V 4, 9). The cause was the fact that 'the change in life and food injured my health, and even if there was a great deal it was not sufficient. Fainting fits began to increase in me and I had such bad heart trouble that those who saw it were very frightened, as were others'(V 4, 5).

Given that the physicians of Avila were unable to heal here, her father took her to Bacedas, to a famous healer, but there this 'medical' treatment was more injurious than her own illness: 'after two months, despite the medicines, life had almost abandoned me, and the gravity of my heart trouble from which I wanted to get better was so strong that sometimes it seemed to me that bitcuss her illnesses and there is an abundant literature on the subject. But at that time Teresa had already overcome those years of illness living a full life, a life that was intense and full of human relationships and activity, an intense internal and external life, embracing the task of reforming and founding eighteen convents of the Carmel, overcoming every kind of difficulty, which today seem incredible to us for a woman of the sixteenth century. Only a woman of great physical, mental and above all spiritual capacities would have been able to perform tasks such as these. Teresa certainly

ing teeth wanted me to separate me from it. I had a constant fever and I was worn through, because for almost a month they had given me a purgative every day, I was so worn out that my nerves began to contract, with almost unbearable pain which meant that I had no rest night or day, and I was very sad' (V 5, 7).

Not seeing any improvement in her condition, her father took her back to Avila. Her physicians thought she would die and said that she had tuberculosis. She was twenty-one and on the night of 15 August 1539 'I had a crisis that lasted more or less four days'(V 5, 9).

St. Teresa remembered all of this twenty-five years later when she wrote the book on her life. Medical doctors disappreciated health, esteemed it, looked for it, recommended it and made it the subject of her prayers to the Lord: 'I wish for health of the body'(cit. 299,5); 'I pray to the Lord that he may continue my health' (cit. 457, 8); 'I am in better health than usual. May God grant it body and soul as I wish' (cit. 2, 14).

With great wisdom, Teresa learnt to overcome illness and no longer wanted to depend on her pain: 'I clearly see that in many things, although in fact I am ill… when I am not so much cared for and treated, I have much more health' (V 13, 7). She recognised the need to care for herself primarily by advising others: 'it is more important to give oneself to others than be ill' (cit. 234). 'I do not deprive myself of every-

thing that I see as necessary, which is not little, and even something more than is common in these parts' (cit. 10).

Illness, like everything else in her life, she addressed in a direct way: 'Until I imposed on myself that I would no longer worry about my body and my health, I was always bound without being of use' (V 13, 7). And she incarnated this with patience and faith. These are the virtues that led her to distance herself from it: 'when the Lord sees that it is needed for our good, health; when not, illness. May it all be blessed' (cit. 2, 4). And above all with love: 'at times illness itself is true prayer, when it is the soul that loves, in the offering of love. Here love acts' (V 7, 12). Teresa learnt to live her illness with peace and joy, to the point of being immense joy, which was the fruit alone of her union with God: 'nothing that takes place on earth will afflict it… neither illness, nor poverty, nor death'(M 5, 3,3).

I hope that all of you will have the feelings with which Teresa overcome illness: wisdom, patience and above all union with God. Only God is enough: this is the belief that gave meaning and fully filled Teresa's life. The rest is important because it helps us to live our union with God and our service to others.

As you well know, we are going through a profound transformation of culture as regards matters connected with health, reproductive health, scientific research on embryos, euthanasia, in definitive terms the radical idea of the nature of life and human beings. These are subjects that concern 'conscience, responsibility and solidarity in the health-care/social world', as the slogan that you have chosen for these Days has it.

Without going too far away from our subject, yesterday the Council of Ministers, denying the scientific evidence on the origins of life and ignoring the great demonstrations that were held in favour of life, such as the 'Madrid Demonstration', approved, as was predicted, the Bill on the 'Voluntary Interruption of Pregnancy and Sexual and Reproductive Health', which means the right of a woman to have an abortion from the fourteenth week of pregnancy until the twenty-second when there is a danger to her life or health, or when there are grave anomalies in the foetus. Abortion is guaranteed as a part of the services offered by the National Health Service as a public and free service and this pre-supposes a juridical change in the law on freedom of conscience to which a large number of medical doctors and health-care workers appeal in order not to practise abortion. A few days prior to this, the Minister for Health announced that the so-called 'day after pill' will be sold in pharmacies without a medical prescription and with no application of an age limit. These are two examples of contemporary news that directly bear on conscience, on responsibility and on solidarity as regards Catholic health-care workers.

I am also convinced, like all of you, that 'together we can'. This is the subject of the second paper of these Days. Together we can, first of all through our union with Christ, as Teresa of Jesus did. Together we can in communion with the Church, which confesses one Lord, one faith, one hope unified in one body, one Spirit, one God and Father. The Magisterium of the Church offers Catholics and society a very abundant doctrine in favour of life and the human being, which you know well.

A great 'Yes' to human life must occupy the central position in our ethical reflection on the dignity of the person. Respecting human life, the dignity of the person, care for the health of the individual and the community are the primary duties and joys of a medical doctor.

I hope that all of you will pass these Days in peace, with joy and wisdom, divine and human wisdom, during the Easter festivities that we are celebrating. I hope that this will be a reflection that will transform life into prayer and prayer into life, according to the model of St. Teresa, a woman who occupied the same geographical space that you will over the next few days.

Greetings from Rafael Palmero

1. As Regards your Challenges

In the letter that you sent me some time ago, inviting me to take part in these National Days, you let me know which are the most urgent challenges that you have to address: the renewal and the internal and external energising of the association, the need for constant ethical and moral reflection on our professional activity, and the role of Christian witness in the world of health and life, with special attention being paid to the weakest and most in need. These are important challenges that require a suitable response. At these moments hurried, incidental or utilitarian responses are of no use. These kinds of response, which may appear to be effective in essential terms, are examples of flight because they accommodate reality without solving the problems.

We must keep silent and listen to the Lord who is amongst us and calls us to be faithful to what we are. These challenges, read with care and listening to the words of God, refer us back in the ultimate analysis to the identity of your association. Expressed in other terms, they are an invitation to be aware of what we are.

The introduction to the Statutes of the Association states that you are Christian health-care workers, that you want to carry out in the world of health and illness the mission that Jesus in his Church entrusted to us.[1] This identity cannot be taken for granted. When a Christian health-care worker, called on by other things, loses sight of what he or she is, he or she does not find in himself or herself the meaning of what he or she does. In these circumstances, the hurry of events, routine or abandonment always appear

on the horizon as a temptation. It is thus advisable to return to one's identity and always keep it in mind in order to address the challenges that face us with consistency and faithfulness. It is in our identity that we should try to look for lasting responses.

2. The Parable of the Good Samaritan (Lk 10:25-37)

When reflecting on the title of these Days, namely 'Conscience, Responsibility and Solidarity in the Health-Care/Social World', there came to me the words of John Paul II that were spoken on the threshold of the Jubilee of the year 2000: 'I extend a warm invitation to those involved professionally or voluntarily in the world of health to fix their gaze on the divine Samaritan, so that their service can become a prefiguration of definitive salvation and a proclamation of new heavens and a new earth "in which righteousness dwells" (2 Pt 3:13)'.[2]

Following this approach, I invite you to think with calm and peace about the parable of the Good Samaritan so that with awareness of your identity you can respond to challenges and grow in solidarity towards the sick. 'From century to century the Christian community', declares the apostolic exhortation, *Christifideles laici,* 'in revealing and communicating its healing love and the consolation of Jesus Christ has reenacted the gospel parable of the Good Samaritan in caring for the vast multitude of persons who are sick and suffering. This came about through the untiring commitment of all those who have taken care of the sick and suffering as a result of science and the medical arts as well as the skilled and generous service of healthcare workers'.[3]

I offer this parable to you for two reasons. First of all because 'The example of Christ, the good Samaritan, must inspire the believer's attitude, prompting him to be "close" to his brothers and sisters who are suffering, through respect, understanding, acceptance, tenderness, compassion and gratuitousness'.[4] Secondly, because 'The parable of the Good Samaritan remains as a standard which imposes universal love towards the needy whom we encounter "by chance"'[5]. A sick person is a source of identity for a Christian health-care worker. In the encounter with him or her your identity is expressed in mercy, in responsibility and in solidarity.

3. Mercy Manifests the Christian Identity

According to Luke, one of the characteristics of God (cf. Lk 1:54; 6:36) is the explanation of the behaviour that Jesus adopts towards the poor, the sick and sinners (cf. Lk 17:13; 18:38). Faced with a sick person, one should not pass by or change direction. A Christian health-care worker, who in a sick person finds his reason for existence and meaning of life, *must go up to him and look at him* (cf. Lk 10:33). The Samaritan, who had not expected that day to have met a wounded man, had very different plans. Faced with the unexpected, he does not change his route but, instead, remains on the path he was walking. A Christian health-care worker knows how to stay, he or she is able to change his or her pastoral programme because he or she wants to come to the sick person that he or she has encountered in a hospital, in a clinic or during a visit.

We have to stay in order to look. To look means to move out of ourselves and take our eyes off ourselves in order to see the other. Our look reawakens the dynamic of the will. We do not look as passive spectators but as actors involved in the mystery of a sick brother. If we look with eyes of faith, the sick person is no longer an anonymous person but becomes, instead, our brother. When we look in this way, we love.

Our look makes possible mercy and generates compassion (cf. Lk 10:33). The Samaritan felt compassion, had mercy, and was merciful. Compassion emerges when the other enters the life of the Samaritan. Compassion is relational and requires the presence of the other, who is not indifferent. Mere proximity does not generate love, but love generates proximity, it is love that makes us neighbours. As John Paul II declared: 'This love makes itself particularly noticed in contact with suffering, injustice and poverty - in contact with the whole historical "human condition," which in various ways manifests man's limitation and frailty, both physical and moral. It is precisely the mode and sphere in which love manifests itself that in biblical language is called "mercy."'[6]

As a consequence, nearness, a look and compassion bring out our Christian identity: be aware of your identity when you draw near to a sick person, when you look at him or her and when you feel compassion for him or her.

4. Responsibility Refers Back to a Dialogue of Love with God

Although mercy makes us neighbours, a Christian health-care worker discovers in a sick person that mediation that is required to respond with faithfulness to the Christian vocation: Christ, in making himself present in a sick person, calls to us. Vocation is a dialogue of love between God who calls and man who answers. The responsibility of a Christian health-care worker refers back to a dialogue of love with God which takes place in the encounter with a sick person.

The Good Samaritan made himself a neighbour to the man, he dressed his wounds, and he poured oil and wine onto them (Lk 10:34). To treat and bandage the wounds the Samaritan did not hesitate to dismount his horse. Love if it is love stoops down; it reaches down. Paul reminds us of this in the Christological hymn of the Letter to the Philippians: 'who, though he was in the form of God, did not count equality with God a thing to be grasped, but emptied himself, taking the form of a servant, being born in the likeness of men' (Phil 2:6-7). This stoop-

ing down makes possible the performance of the task of treating and bandaging wounds. Love, which springs from the encounter, requires one to place oneself at the same level as the sick person. In imitation of Christ you should stoop down so that a sick person can recover his or her health. So respond to your vocation, be, that is to say, responsible, in devotion, in self-giving, and in gratuitousness. These are the responses to an experience of love that has sprung from an encounter with a sick brother. Only love for a sick person, in which we discover Christ, makes us responsible.

Responsibility supports and justifies the need for on-going training. The up-dating of personnel who work in such a delicate sector of society is extremely urgent and this is even more the case when a sick person entrusts us with the good of his or her life. In this sense, the words of Benedict XVI are eloquent: 'Individuals who care for those in need must first be professionally competent: they should be properly trained in what to do and how to do it, and committed to continuing care. Yet, while professional competence is a primary, fundamental requirement, it is not of itself sufficient. We are dealing with human beings, and human beings always need something more than technically proper care. They need humanity. They need heartfelt concern... Consequently, in addition to their necessary professional training, these charity workers need a "formation of the heart": they need to be led to that encounter with God in Christ which awakens their love and opens their spirits to others. As a result, love of neighbour will no longer be for them a commandment imposed, so to speak, from without, but a consequence deriving from their faith, a faith which becomes active through love (cf. *Gal* 5:6).[7]

5. Solidarity Springs from Love

The compassion of the Samaritan is expressed through his actions. True love is creative, it does not abandon but instead it looks after. Love is revealed in commitment, in faithfulness and the need for continuity. True love never abandons a sick person to his or her destiny, it ends the work that has been begun, and it is at one with him.

'Then', the parable continues, 'he set him on his own beast and brought him to an inn, and took care of him. And the next day he took out two denarii and gave them to the innkeeper' (Lk 10:34-35). Solidarity with a sick person seeks neither gratification nor applause, it is neither momentary nor skin-deep. Solidarity has its own roots in an objective tie with a sick person that springs from love: love requires solidarity. From this point of view, solidarity with a sick person should not constitute an option for a Christian health-care worker.

From this solidarity with a sick person, in the contemporary socio-cultural context two urgent tasks flow: the defence of life and the promotion of a health worthy of man. Solidarity commits us, like other Samaritans, to heal, to treat and to defend the life of a sick person. People deceive themselves when they 'think that they can control life and death by taking the decisions about them into their own hands. What really happens in this case is that the individual is overcome and crushed by a death deprived of any prospect of meaning or hope'.[8] And Benedict XVI stresses that: 'In fact, it is necessary to assert vigorously the absolute and supreme dignity of every human life'.[9] Faced with the threat that is made to the life of man at its beginning and at its final moment, solidarity is manifested in the proclaiming of the Gospel of Life: you should be through your work 'stewards and servants of human life'.[10]

Solidarity requires of you a second task: the promotion of a health that is worthy of man. The danger exists of transforming health into an idol to which other values are subordinated. This reductive vision of health does not take into account the spiritual and social dimension of the person. Health is not limited to biological perfection: 'life lived in suffering also offers room for growth and self-fulfilment, and opens the way to discovering new values'.[11] Solidarity must encourage us to work for a health that is based upon an anthropology that respects the person in his or her totality. From this point of view, health 'far from being identified with the mere absence of illness, strives to achieve a fuller harmony and healthy balance on the physical, psychological, spiritual and social level'.[12]

6. 'Together we Can'

The slogan that you chose for these Days, 'Together we

Can', refers us to communion. A communion which for us is sacramental when we remember our Lord Jesus Christ, when we celebrate the Eucharist.

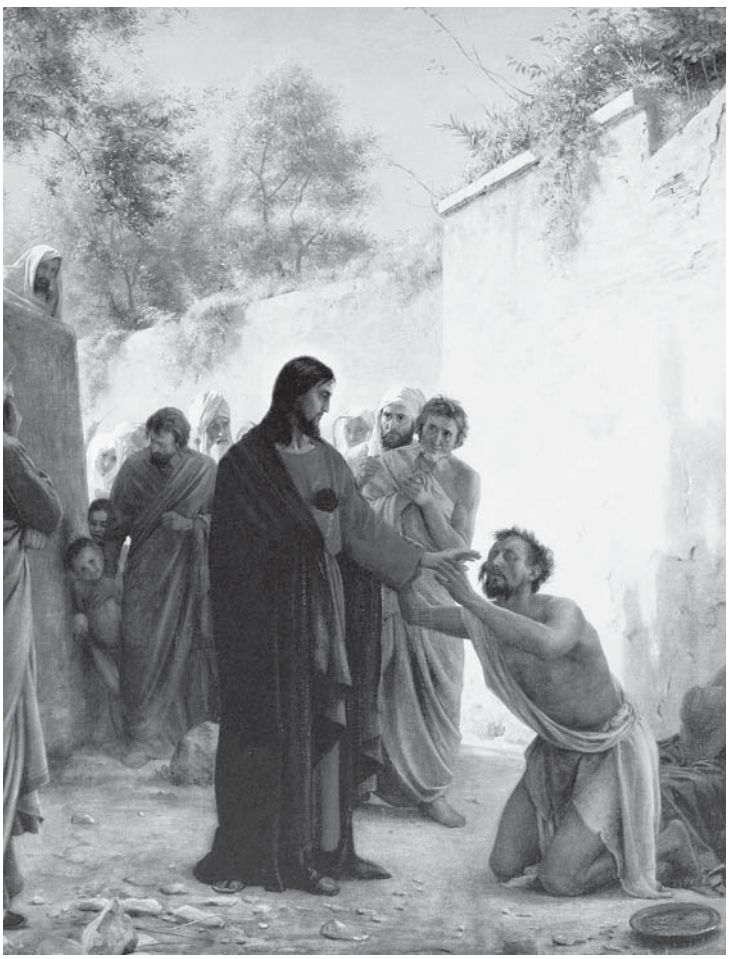
We, too, we need to be treated, we need someone who will bandage wounds. Christ, the Good Samaritan, washes our tired feet, treats our wounds, takes responsibility for our sufferings, and redeems us through his death on the cross. The Eucharist is a school of love at which we learn to be Samaritans. 'The service rendered to the person who is suffering in body and soul takes its meaning from the Eucharist, finding in it not only its source but also its norm. It was not by chance that Jesus closely united the Eucharist with service (Jn 13:2-16), asking the disciples to perpetuate in memory of him not only the "breaking of the bread", but also the "washing of the feet"'.[13]

When we sit at the Eucharistic table we allow our feet to be washed by Jesus and we enter into communion with Christ and our brothers through the shared bread and the blood shed for us. In the Eucharist, service is an expression of Eucharistic communion. It follows from this is that in service to our sick brother we must all be united: this is the force that is achieved in the frailty of your service and your dedication. 'It thus appears clear', observes Benedict XVI 'that it is specifically from the Eucharist that pastoral care in health must draw the necessary spiritual strength to come effectively to man's aid and to help him to understand the salvific value of his own suffering'.[14]

I invite you to take part in the Eucharist by giving a hand to Mary, our Mother. In this way you will experience that the impossible becomes impossible and how what has been separated can be united.

Notes

[1] Cf. 'Estatutos de la Asociación de Profesionales Cristianos, Preámbulo'.
[2] JOHN PAUL II, 'Message of the Holy Father for the World Day of the Sick for the Year 2000', 6 August 1999.
[3] JOHN PAUL II, apostolic exhortation *Christifideles laici,* n. 53.
[4] JOHN PAUL II, 'Message of the Holy Father for the World Day of the Sick for the Year 2000', 6 August 1999.
[5] BENEDICT XVI, *Deus Caritas est*, n. 25.
[6] JOHN PAUL II, encyclical letter *Dives in misericordia*, n. 3.
[7] BENEDICT XVI, encyclical letter *Deus Caritas est*, n. 31.
[8] JOHN PAUL II, encyclical letter *Evangelium vitae*, n. 15.
[9] BENEDICT XVI, 'Message of the Holy Father for the World Day of the Sick for the Year 2009', 2 February 2009.
[10] JOHN PAUL II, 'Message of the Holy Father for the World Day of the Sick for the Year 1999', 8 December 1998, n. 6
[11] JOHN PAUL II, 'Message of the Holy Father for the World Day of the Sick for the Year 2000', 6 August 1999. n. 13.
[12] *Ibid*., n. 13.
[13] *Ibid*., 8.
[14] BENEDICT XVI, 'Message of the Holy Father for the World Day of the Sick for the Year 2008', n. 4.



Suffering, a School of Life: the Servant of God Manuel Lozano Garrido

After some brief biographical references, I have organised my paper into two parts: suffering, a school of life, and Lolo-Manuel Lozano Garrido, a witness to the value of suffering.

Manuel Lozano Garrido was born in Linares (Jaén) in 1920. He joined Catholic Action in 1931. His illness appeared in 1942 and in 1943 it forced him onto a wheelchair. In 1956 he established the review *Sinai*, a journal for sick people. He lost his sight completely in 1962. He published a large number of books and in 1969 he received the 'Bravo' prize for journalism. He died in Linares on 3 November 1971. In 1994 the process of his canonisation began in Jaén.

1. Suffering, a School of Life

a. Life is a gift

Life is life, it is a gift, a gift from God that we must love, care for and steward. We must say 'yes' to life and 'no' to manipulation. Life is neither of the right nor of the left, it belongs to no political party, and it is not the product of a laboratory; life is from God, and we are its sole stewards.

We are born to live. Man's commitment is life and for this reason we must learn to live: we must love life, fall in love with life, give thinks for the gift of life, enjoy life and share life; allow ourselves to be surprised by life, and know how to live new, different and unusual moments. How beautiful it is to discover life and to live it with hope, with confidence, with the wish to fight; to live and not to give any space to sadness, to boredom, or to fear. To love life, to allow the new to come in, to look at the infinite, to open doors and windows to life so that light, joy, self-giving and love come in.

Yes to rich, abundant, full life, that life that Jesus of Nazareth has promised us: 'I have come so that they may have life' (Jn 10:10).

The magnificent encyclical of Pope John Paul II, *Evangelium vitae,* is a text for profound analysis. As ministers of life we are called to proclaim the value of life, to serve life, to celebrate life and to evangelise life.

b. Pilgrimage through suffering

Yes to life, and yet life is constantly subjected to threats. And here are some of them: drugs, alcoholism, road accidents, consumerism, depression, sex, the emptiness of life; abortion, euthanasia, hunger, war, death against life, and an infinity of diseases.

Here is a rapid list: almost a thousand million people suffer because of poverty, malnutrition and diseases; every year 46 million people die; almost 850 million people live in zones afflicted by malaria; in many countries the average life span does not reach the age of fifty and the infant mortality rate is between 100 to 200 every thousand. In the world there exist: 10 million epileptics; 15 million lepers; 52 million people who are deaf and dumb; and 50 million paralytics.

12% of the world's population suffer from a mental anomaly; we may also add AIDS to this list, as well as drug addiction, alcoholism, old age, unemployment, migrations etc. These are the statistics of shame that are present in our society. But it is also a long journey, a great pilgrimage of the whole of humanity through the map of suffering that speaks to us about its universality and unites all the peoples of the world: the rich and the poor, the ignorant and the wise, believers and non-believers.

c. Does illness have a meaning?

On 11 February 1984 Pope John Paul II published his encyclical letter *Salvifici doloris* on the Christian sense of human suffering. In this work the Supreme Pontiff states that suffering is a universal subject which accompanies man (*SD*, n. 2) and which must be accepted as a mystery (*SD* n. 8 and n. 11) and he adds that in order to gain insight into the real answer to the meaning of

suffering we have to turn our gaze to the revelation of divine love, the ultimate source of the meaning of everything that exists. Love is also the richest source of the meaning of suffering. It is the answer given by Christ on the cross (*SD*, n. 13). It is the path followed by Christ who accepted pain, and experienced by giving it a meaning of salvation and salvation. He give himself totally unto death on the cross, but his resurrection defeated death. From that moment onwards human suffering has acquired a meaning, it has been transformed, together with the suffering of Christ: 'if a grain of corn that falls to the ground

does not die it remains alone, but if it dies, it produces much fruit' (Jn 12:34).

d. Suffering is a key and opportune moment, a kairós:

For a sick person who dwells upon his or her life and begins to reflect more seriously on its meaning at a time of illness; a time of God which passes and perhaps finds us less distracted.

Pain and illness are a place of observation, a school, a university that teaches us so many things and an opportunity to embrace life and at times a place for authentic conversion and apostleship.

Many saints and simple people have achieved a great positive journey through suffering: Ignatius of Loyola, John of God, Camillo de Lellis, John Paul II, Lolo, and an almost infinite etcetera. This is an experience that is confirmed every day in hospitals and in family life.

2. Lolo, The Servant of God Manuel Lozano Garrido, a Witness to the Value of Suffering

Having as our frame of reference the above analysis, I will now point out certain human aspects of Lolo and other aspects connected with his illness, in the sense of how he lived out his illness. I will do this in telegraphic form.

a. Human aspects in Lolo

A positive spirit: life has a meaning, independently of the objective circumstances; a great generosity of spirit: Catholic action and service to his parish community (minister of the Eucharist *ante litteram*); extraordinary will power; a practical spirit: concreteness in professional activity and decisions – first teaching and then journalism; a spirit that was totally impassioned: nothing stopped him, not even his forced immobility; an open and advising mind: a thirst to share everything with everybody, that is to say to communicate (an adviser of young people, a journalist, a writer); and a man of exceptional faith.

b. Some aspects connected with his condition of illness and suffering

A trusting acceptance of his condition without allowing himself to be lowered by desperation: three human approaches to pain – desperate rejection or discouragement (God has abandoned me); resignation (God has sent this, God wants it); understanding of, and the attribution of a role to, suffering in the redemptive work of Christ; giving meaning to the new direction of life

from the point of view of faith (union with the crucified Christ) and from a human point of view (change in professional direction); the courage to bear pain and suffering for God and for the Church – readiness until martyrdom; the rediscovery of the communal value of pain and suffering (offering one's own suffering to God for the community, offering sufferings together with other people to contribute to the redemption of the world); the dimension of, and need for, the witness of the person who suffers; suffering as a source of praying thanksgiving to God – 'I fall on my knees and give free expression to gratitude… I do not want complaint; give me instead a smile'; communicating a certain normality of life in pain in order to bear witness to nearness of God: joy, a smile, a good mood, cheerfulness…; holiness in simple and daily things; awareness of the nearness and at the same time of the transcendence or otherness of God: 'you are here, sitting next to my chair, and affectionately I put my arm around your shoulders… I have to dream that I am seeing you; I will die if I do not see you, almost hidden and always unreachable'.

From these few characteristics, one can observe, and I repeat the point, how the Servant of God Manuel Lozano Garrido was transformed and matured by the intense experience of pain and suffering, moving from an active and involved life to the active contemplative dimension. His faith always became stronger with aware acceptance of pain, to which he was soon able to give a meaning – participation in the work of redemption of Jesus Christ. This enabled him to transform his illness into an instrument of evangelisation.

Conclusion

Lolo was an authentic witness to the values of the Kingdom, lived in suffering, in an environment which at first sight could appear to us to be negative, whereas in fact it is not. Yes, pain, suffering and illness have a meaning, this is proclaimed by the Lord with his words and with his life that was given totally, passing through Calvary, unto death on the cross. The Church proclaims this in its preaching and in its celebrations. In his apostolic letter *Salvifici doloris*, n. 30, John Paul II uses these very strong phrases: 'suffering is present in the world in order to release love, in order to give birth to works of love towards neighbour, in order to transform the whole of human civilisation into a 'civilisation of love''. Furthermore the Supreme Pontiff states that the suffering of man 'is above all a call. It is a vocation' (n. 26). A mysterious call to love more and to share in the infinite love of God for mankind.

Paul Claudel said: 'God did

not come to eliminate suffering or to explain it. He came to fill it, to give it meaning through his presence'.

Faced with pain, the man who does not believe blames God for everything that happens and cries out: where are you God? The man of faith, on the other hand, tries to discover the meaning of his life and to give it a meaning even when it is lived out with difficulty and in illness. Faith does not remove cancer, blindness or any other illness, but it does propose choosing between pain that does not have meaning and pain that has meaning. To serve life is to specifically this – to give a meaning to suffering and death.

And we see this broadly and significantly reflected in Lolo, as an example, as a model. He understood the teaching of Jesus and the Church, which have always stimulated people to fight for health, knowing that despite all his advances man will never be able to eliminate illness or death.

The Church also teaches that a sick person is not a passive and useless person but a person with a great mission – that of being a witness. The Church equally invites people to treat a sick person with all the technical means possible but also to look after him or her with great humanity and respect for the person. The eternal example is the Good Samaritan, the perfect icon of how to draw near to suffering man (Lk 10).

Indeed, Lolo and many other men and women have grown and matured humanly and spiritually at the school of suffering. They have known how to enjoy all the riches that are contained within it, they have felt the presence of God in their lives which thanks to Him became rich and full.

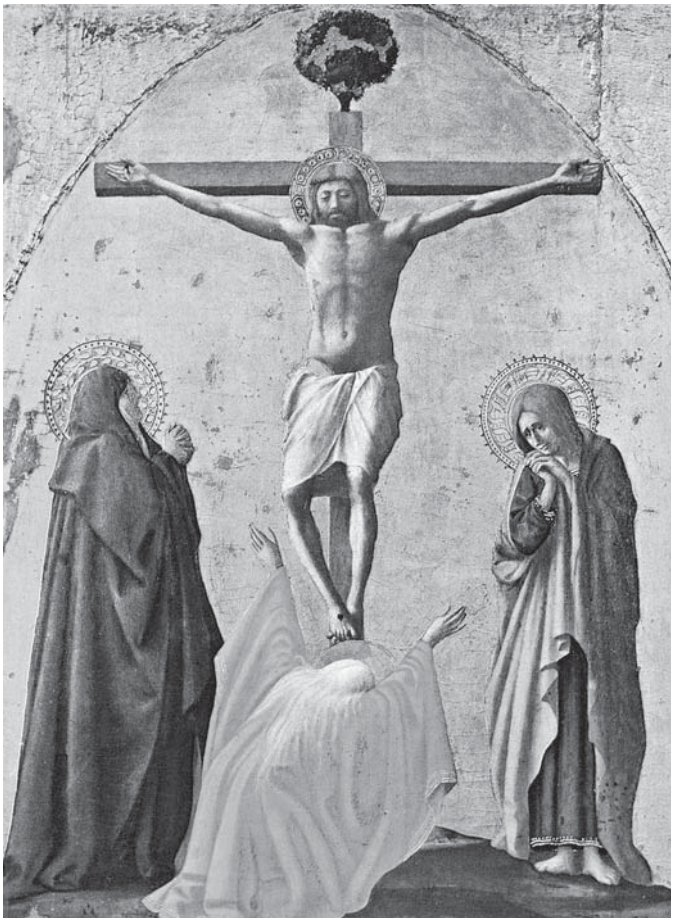
I will conclude this paper with a sentence of Pope Benedict XVI and with a Jewish story.

I will begin with a sentence of the present Pope which reads as follows: 'May your kingdom come! If the beloved, love, the greatest gift of my life is near to me, if I can be convinced to the depths of my heart that who loves me is near to me, even in situations of tribulation, joy will be in the depths of my heart, which is greater than all suffering' (4 October 2005).

And to end my paper, here is a Jewish story. 'It is said that a disciple asked his teacher, why do the good suffer more than the bad? His teacher replied, listen a man had two cows, one was strong and the other was weak – on which of the two did he place his yoke? Obviously on the stronger cow, replied the disciple. The teacher than concluded, the merciful does the same, for the world to move forward he places the yoke on the good'.

And this is what God did with Lolo.

H.E. Msgr. JOSÉ L. REDRADO OH,
Secretary of the Pontifical Council for Health Care Workers, the Holy See.



Pontifical Council for Health Pastoral Care

Pontificio Consiglio per la Pastorale della Salute

Pontifical Council for Health Pastoral Care

The Fifty-Sixth World Leprosy Day - Sunday 25 .

September 10, 2009

HEADLINES

Ephphatha!: The Deaf Person in the Life of the Church

XXIV International Conference
(19-21 November 2009)

The general theme chosen for this year's International Conference wishes to respond to the numerous requests that we have received, asking for the possibility of organizing a Symposium for deaf people in the Vatican. [View more]

HIGHLIGHTED

Resignation of the President of the Pontifical Council for Health Pastoral Care and appointment of the successor

The Holy Father Benedict XVI has accepted the resignation of His Eminence Javier Cardinal Lozano Barragán, from the office of President of the Pontifical Council for Health Care Workers (for Health Pastoral Care) due to age limit, and appointed Bishop Zygmunt Zimowski of Radom, Poland, to succeed him, elevating him at the same time to the dignity of Archbishop. [View more]

NEWS UPDATE

Alarmante nexo entre pobreza y patologías visuales, advierte el dicasterio para la Salud

«La santé est une tension vers l'harmonie et vers Dieu»

La souffrance doit être combattue, déclare le card. Barragan

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